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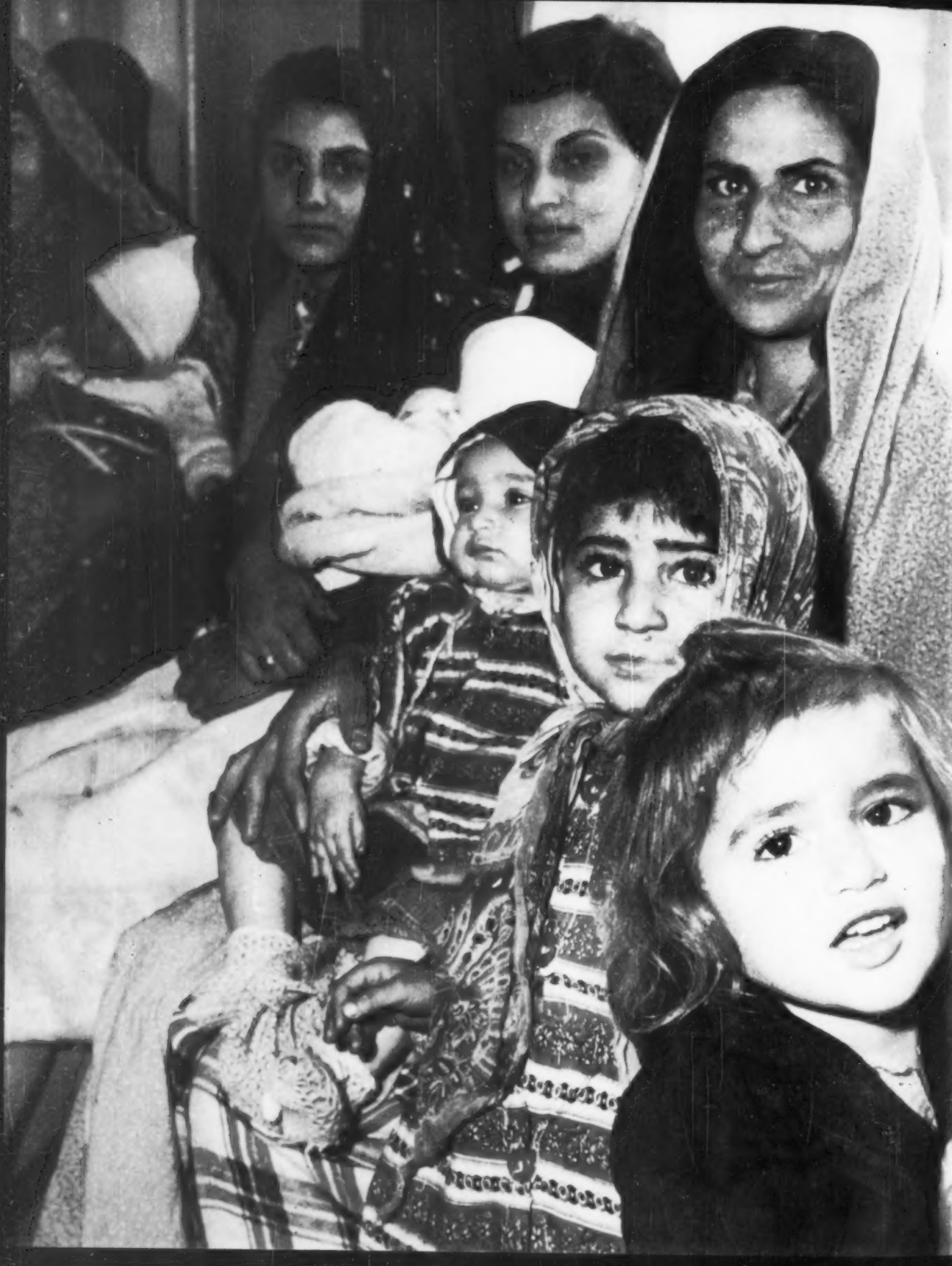

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MOTHERS AND CHILDREN waiting their turn at the children's clinic of the American Joint Distribution Committee's hospital in the Mahalleh, or Jewish quarter, of Teheran, Iran. How the committee reorganized its health services for children to introduce a family health program is described on page 83.

Helen Cohn left the American Joint Distribution Committee this March to join the staff of the Harvard School of Public Health. A South African, trained in nursing in South Africa, in midwifery in England, and in public health at Harvard, she has worked with the JDC in Iran, Morocco, and Tunis, and with the World Health Organization in Israel. For 12 years she was nursing director at the Institute of Family and Community Health in Durban.

Dr. Austin W. Matthis, who was health officer for Imperial County, Calif., when the project described in this issue was initiated, has since become health officer in the Sacramento City and County Health Departments. Dr. Belle Dale Poole, who has been with the California State Department of Public Health for the past 13 years, was previously in private practice as a pediatrician. Gwendolyn Beckman, who has been with that department for the past 16 years, received her social work training at the Simmons School for Social Work and the University of California at Berkeley.

Annie Lee Sandusky was on leave of absence for 3 months from the Children's Bureau to participate in the Cook County (Ill.) study of families in the aid to dependent children program she describes here. Her specific task was to train the interviewers for the study. Mrs. Sandusky has been with the Children's Bureau for 14 years. Before coming to the Bureau, she was head of the casework department and instructor in casework and child welfare at the Atlanta University School of Social Work.

R. Robert Geake (left), who is studying for his doctorate in education at the University of Michigan in the summer, directs a children's reading clinic at Ferndale, Mich. He also serves as educational consultant and tutor for the Methodist Children's Home Society, Detroit. Wallace M. Lornell (right), a graduate of the New York School of Social Work, has been in his present position for the past 5 years. Previously he was cottage life supervisor at a children's home in Lake Bluff, Ill.

Elizabeth K. Radinsky has spent her entire professional career in the foster care field. She was director of casework for Jewish Youth Services in Brooklyn from 1940 until the agency's merger a year ago with the Jewish Child Care Association of New York, where she now heads the foster home-care and foster family day-care programs. Mrs. Radinsky holds master's degrees in social work and social science from New York University and the University of Pennsylvania, and a certificate in the advanced curriculum of the Smith College School of Social Work.

◀ *the authors*

A FAMILY HEALTH PROGRAM IN TEHERAN

HELEN COHN
Formerly Public Health Nursing Consultant, American Joint Distribution Committee

FOUR YEARS AGO the American Joint Distribution Committee, a Jewish health and welfare organization widely known as the JDC, initiated a family health program in the Mahalleh of Teheran, Iran. The Mahalleh is that part of the city where the people are poor, live in overcrowded conditions, and are provided with the least adequate of the city's amenities. It has a population of approximately 14,000, and, although known as the Jewish quarter, about 6 percent of its inhabitants are Moslems. The people live at peace with each other, and the JDC's health services there are available to all elements of the population.

Since 1950 the JDC has worked in conjunction with a local Jewish committee known as the Kanoun Kheir Kha, a group of people with a real sense of responsibility for the poorer section of the community.

The program in 1957 included:

1. A hospital comprised of a 12-bed maternity ward and a 20-bed pediatric ward, adult and pediatric outpatient clinics, and a dental clinic.
2. A maternal and child health center including prenatal and well-baby clinics some distance away from the hospital. Dietary supplements for needy children and layettes for the newborn were distributed from this center.
3. A school health program providing care and referring sick children to the hospital.
4. A sanitation program concerned with hygiene in the homes, schools, and shops.
5. A nursing school for training nurse aids for the program's services.

Although these services were administered as individual units, there was some coordination by virtue of their belonging to the same agency. Reassignment of nurses took place according to staff requirements; patients were referred from one service to another; school children to the hospital, prenatal patients to the maternity ward, and in some instances, babies from the well-baby clinic to the hospital's pediatric clinic. Case records, however, were duplicated in each service and there was no coordinated planning for the patient.

Over the years the JDC had helped to open additional services as needs became apparent, and insofar as it was possible to meet them. Prenatal care, supplementary feeding and immunization, as well as medical care for the sick, had lowered the infant mortality rate, reduced the incidence of communicable disease, and increased the people's understanding of the use of health services. These were dramatic changes in the standard of health in the community. But there remained much to be done.

A visit to the Mahalleh revealed the hazards of the environment to the healthy growth of children. In addition to the overcrowding in homes, there was a lack of understanding on the part of the people of hygiene and healthy habits. Attendance at the pediatric clinics was largely of children with diseases arising from—or closely related to—their family and environmental conditions, so that neither prevention nor treatment of such diseases could be properly achieved in the clinic alone. Furthermore, it was often the least informed mothers who did not come to the doctor or did so only when their children were desperately ill.

The JDC questioned whether it was not possible to make the services more far reaching and more fully available, and to relate more effectively environmental and social factors with the health of the mother and child. Therefore, in 1957 an attempt was made to reorganize the services on the basis of a family health program.

What It Is

A family health program is an integrated public health and medical care program in which the family,

rather than the individual, is the unit of practice. It aims at promoting the standard of health of the total family so that each individual enjoys the advantage of a healthy environment. Thus the child is seen, not as one of a group of well babies or sick babies, but as a member of a family, and his care includes the "treatment" of the environment, both physical and social, on which he is dependent for healthy growth and development. Similarly, the pregnant woman is not seen as one of many pregnant women in a prenatal clinic, but as a member of a family where the health of husband and children has such influence on the mother's health and on the coming baby's, that they too are the concern of the doctor and nurse giving maternity care. The family is chosen as the unit of practice because its members share a common environment and common resources, and because of their dependence on and responsibility for each other.

A program aimed at promoting the health of families requires that a team of health workers be assigned to a group, or neighborhood, of families and learn to know their state of health and need of health services. A variety of professional skills is required to meet the complexity of family conditions relating to their health.

The program introduced in the Mahalleh was not a comprehensive family health service. The team lacked social workers, health educators, and other professional workers to adequately meet the problems emerging from a closer knowledge of the family. The agency lacked the resources to raise the economy of the family to a level more conducive to health, or to provide the community with basic environmental services. The program was, nevertheless, family centered in its reorganization of existing maternal and child health services, in its focus on family factors relating to health and disease, and in its reorientation of staff to a coordinated family approach.

It is the purpose of this paper to outline the type of staff training which preceded the introduction of the program, to discuss the organizational changes which were effected, and to comment on the function of the nurse in this setup.

Training

Lectures and discussions were held before the start of the program and were attended by nursing and sanitation supervisors, specialists who would be involved in the program, i.e., gynecologist, dentist, and so forth, and the staff of doctors, nurses, and sanitarians who would constitute the "teams." These latter and their functions at the time included: three physicians, one in charge of the Maternal and Child Health Center, two in pediatric outpatient clinics; eight behyars (public health nursing assistants with 2 years' basic training and a brief orientation course in public health) working in the prenatal and well-baby clinics; three sanitarians in a home environmental program; and four admission clerks from the well-baby clinic and the hospital outpatient clinic.

Inherent in the presentation of the new type of organization was the redefinition of the functions and a reevaluation of the practices of every individual in this group. Not only did the participants represent a number of hitherto unrelated services but they were people of such varying levels of qualification and status that it was questionable whether they could sit together in a class or discuss their functions together. Furthermore, it was clear to them from the beginning that they were about to embark on a form of practice, which, in Teheran, had all the hazards of an experiment.

The introduction of the family health service was dependent on this group's understanding of new principles and willingness to put them into practice. The course was therefore designed in such a way as to provide abundant opportunity for discussion of the program and for arriving at conclusions which would motivate the members of the group to participate wholeheartedly in the reorganization of the service and the redefinition of their functions.

Eight 2-hour sessions of lecture and discussion were held. For example, a lecture on the subject of family structure and the related growth and development of the individuals in the family group led to discussion of the influences determining the health of an individual, of the importance of understanding these influences and recording them, and of the appropriate methods for doing this. Thus the need for a family census card, showing family structure and relationships and the best method of obtaining this information, was fully discussed.

Similarly, a lecture on family resources in relation to individual needs led to a discussion of the importance of developing the kind of relationship between the worker and the family which would permit guidance in the home in respect to such intimate details as the use of money or the distribution of food. This called for skills in understanding the dietary requirements of people at different stages of development and the different demands of individuals on the family's common resources.

A lecture and discussion on the growth and de-

velopment of the child within the family revealed how procedures had to be modified to put an accepted theory into practice. A brief résumé of the progression of this discussion follows:

The concept of "normal growth and development" of the child is based on physical, mental, and social standards. Deviations from the normal may result from inadequacies in the family's ability to give care, hazards in the environment, or a defect with which the child is born or which he acquires. Promotion of healthy development and prevention of disorder may be achieved by securing favorable conditions in his family and environment, by reducing the hazards to which he is subjected or increasing his resistance to them.

When deviations occur, the aim of the treatment is to return the child to a pattern of growth normal for himself. Whether the procedure of the service is labeled promotive, preventive, or curative, its aim is to maintain the child in the best possible course. This can be achieved better by one doctor who knows the family, its resources and inadequacies, and knows the child, his growth pattern, resistances, and susceptibilities, than by two doctors, one of whom, seeing the child only in sickness, is unable to relate him to the overall picture. The well-baby doctor, therefore, and the doctor of the pediatric clinic should be merged into the one "family doctor."

In the community to which a team is assigned, there are some children who are well and some who are sick, the same child is sick one day and well the next. Therefore, it becomes difficult to define what is meant by the "well baby." Few babies in this community reach optimum standards of health. Absence of communicable disease or fever might qualify the child for the well-baby clinic, but would this exclude the child with a beginning diarrhea, a discharging ear, or impetigo? Is the underweight child, in need of vigorous nutrition therapy, a sick or a well baby? Should the mother be expected to make the decision as to which clinic is the best for her child? Should not the well-baby clinic and the pediatric clinic be merged into one clinic for the promotion of healthy growth and development?

Bringing well and sick children together raises problems of cross infection in the waiting room and doctor's office; but this is no more of a problem than in the pediatric clinic where children are known to suffer from a variety of infections, or in the well-baby clinic where hidden infections exist. Precautions should be taken in all situations.

A more serious problem might be maintaining health education and immunization in a combined clinic which is likely to become crowded with sick children. However, education of mothers is frequently more effective when they are anxious about their sick children than when their children are healthy.

Convinced of the importance of a coordinated approach to the growth and development of children, the group was ready to relinquish the well-baby clinic and to plan for what came to be known as the "area session."

Staff Assignments

Having studied the implications of family health, the group met to plan methods of introducing new procedures based on the principles they had accepted.

A map of the Mahalleh was prepared and divided into three geographic "areas," each comprising approximately 470 families. The staff was organized into three teams, each with responsibility for one area; that is, one-third of the Mahalleh. Thus the doctor and behyars previously engaged in the child health center and those from the pediatric clinic would now undertake health and medical care for all the mothers and children in their area.

Each team comprised the family doctor, two behyars and one sanitarian, each behyar being responsible for half an area, or 235 families. Supporting the three teams was a staff of supervisors, nurse aides, and health recorders.

Team schedules were arranged, giving time to area sessions attended by doctors and behyars, home visiting by behyars and sanitarians, and team meetings for discussion of reports and evaluation of the service. The two behyars in the team alternated between visiting in the homes and attending the area session, each making appointments with her families to visit the doctors on the days she would be there. In addition, both behyars attended a weekly prenatal session with the gynecologist for patients from their area. The three teams met together once a week to discuss matters related to the community as a whole.

Records prepared for the program included census cards, birth and death notifications, simple case clinical cards on which to record examination of children whether sick or well. An environmental investigation record was designed for the sanitarians, and a community sheet on which the nurse showed the scatter of their home visits to families.

During the period of lectures and discussions, alterations were being made in the hospital to increase beds for maternity care and accommodate the area sessions and records of the family health program.

Family Health Program

When the family health service began in August 1957, a fundamental change in approach had taken place in the staff. In addition to having developed an awareness of the significance of social and economic factors they now considered as the object of their work, not only the patient who attended the clinic but the area to which, as a team, they were assigned and in which they were responsible for seeking out the health needs of the families.

The behyars and sanitarians visited every family in their area for census taking and home sanitation investigations. Meanwhile the doctor, with the alternate behyar, examined patients at the area sessions. Neither the home visiting nor area sessions were confined to surveys, but included treatment, advice, and many kinds of assistance. The families soon learned to know their own team, their session's days, and when to expect their behyar or sanitarian to be visiting in the area. When asked their address they gave not only their street and number but also their area.

Thus the team gained a picture of its community: the number of pregnant women, young babies, and newborn; in which homes the environment was a hazard to health; the families which for economic or emotional reasons could not provide adequately for their children without assistance; what the diseases of high frequency were; the problem of communicable and chronic diseases; and recurring problems in child rearing.

Community Programs

In addition to planning care for individual families, community programs were developed on the basis of the recorded information. Health education on the prevention of common winter accidents was one. Family care in relation to the prenatal program was another. Priorities emerged; one example calling for special planning was the care of "the underweight baby."

In regard to this last, the staff decided first to define what was meant by "underweight." This led to consideration of birth weight, prematurity, expected weight gain, loss of weight resulting from acute disease, and failure to gain weight as a result of prolonged underfeeding. Consideration was then given to ways of preventing or treating each of these factors, and the role each team member would play in this.

Every case of an underweight baby was recorded on a specially designed card, for inclusion in the special program. Causes for the condition were sought by the doctor in an examination of the baby to ascertain the presence of disease; by the behyar through assessment of the diet and the care at home; by the sanitarian through examination of the environment for sources of infection. The team discussed their findings and the doctor directed the program of treatment and of continued observation.

This program achieved marked improvement in the growth of underweight babies. In addition, it had important educational value for the staff and brought to the attention of parents the variety of factors related to the development of their children.

Another "priority program" was the prevention and early treatment of enteritis, in which the team had related functions and planned their work together; again the family became aware of the many factors in the home relating to disease.

Whether a program was based on the care of pregnant women, or arose as a priority such as enteritis or accident hazards, the approach was always to the family as a unit and the aim was to help the family to undertake responsibility for its members. In this regard the relationship which developed between the behyar and her families was of major importance.

The Behyar

As nurses in the prenatal and well-baby clinics, behyars had some knowledge of public health routines; they could weigh babies, do routine immunization, and distribute milk and food supplements. They had also had preliminary training as hospital nurse aids. Their role had been that of assistant to the doctor and they executed his orders under his supervision at the center. In the family health program the behyars attended area sessions with the doctor, but as much as half of her time was spent in the homes, keeping close contact with all the 230 families in her half-area. Like many of the staff, the behyar herself had lived most of her life in the Mahalleh and the conditions were not new to her; as a member of the team with clearly defined functions, she saw it now from a new point of view.

The Mahalleh is drab and overcrowded; it has a poor water supply and inadequate garbage disposal. Narrow streets which wind between the high walls throng with women and children and street venders. Small doors in the walls lead to courtyards around which the houses are built, all their windows and doors opening onto the courtyard.

On entering a courtyard the behyar encounters a group of women, young babies, and children, and perhaps one or two men, washing, or talking, or just idling in the sunshine. She knows the families who share this courtyard and can tell which children belong to which mother, and whether the father is at home because he is sick or because he has lost his job. She knows that a particular baby is due to be vaccinated, or that a mother is pregnant and should be getting milk powder to supplement her diet. She knows that the small bricked pool, a feature of every courtyard, is common to them all. They wash their clothes and their dishes in it, use it for cooking, and children may drink from it; the very young may fall into it, and many have drowned. She knows that an infection in any one of these families is a hazard to them all, but that they will help each other as good neighbors in time of need.

Knowing these people as a "courtyard group" the behyar knows them also as family units. She knows that a family of five or six people lives here in two small rooms where they must all sleep, eat, dress, and store their belongings; that the adolescent daughter

has no place to hide her private possessions or entertain her friends; and that the parents have no place for a private discussion and no possibility of isolating a child with an infectious disease.

Here in the home the behyar talks to the mother about her child's diet and his general progress, and the mother discusses problems of her children, her husband, her poverty, her relationship with an adolescent daughter or a sick child of a neighboring family. Whatever the problem is, it relates to health and the knowledge of it demands action on the part of the behyar.

Considerable responsibility rests on the behyar both in her visiting in the homes and as a member of the family health team. She must be skilled both in the nursing care of children and in observation and interpretation of home conditions. Faced with a variety of family problems, she has to know the extent and the limitations of her function. Certain routines give her assurance in her work; she has standardized criteria for referring and reporting. But her understanding of the significance of her observations has to grow with experience and in discussions with the team.

The behyar's chief function is to promote the health of families through an educational approach applied equally to mothers of sick children and to mothers of healthy babies. Being accessible to the families for all their nursing needs creates countless opportunities for her to develop the kind of relationship which permits her to influence customs. Her caseload includes home care to sick children, routine neonatal visits, and diet advice to pregnant women. But in all cases her goal is to foster in the family, rather than to retain for herself, the responsibility for the care of the individual. She visits to observe the patient's progress and to assist the family members in caring for him, giving them an understanding of his condition as well as the satisfaction of bringing him back to health. Thus the care of the patient at home implies not only care within the family but care by the family.

The Hospital's Role

The hospital became an integral part of the coordinated health and medical program. However, the close supervision and detection in the homes led to early diagnosis and treatment of gastrointestinal and upper respiratory infections, and thus frequently prevented disease from progressing to a degree which required hospitalization.

Children from the area were admitted to the pediatric ward only after it was ascertained that they could not be nursed at home. Those admitted, therefore, were children in whose families there were special needs to be met and environmental conditions to be treated. The team doctor was responsible for the admissions from his area, and supervised the hospital care of his patients. The area behyar visited the child in the hospital, and she and the sanitarian visited his home while he was away.

Every pregnant woman in the area was known to the behyar and was encouraged to enter the maternity ward for delivery. In the 3 years following the initiation of the program, over 99 percent of the deliveries in the Mahalleh did take place in the hospital, all of which had been preceded by prenatal care at the clinic and visits at home by the behyar. In each case, the team doctor examined the new baby in the maternity ward and the behyar visited the mother at the hospital and arranged the date of the first home visit after discharge.

Association between the hospital service and the family health service has helped the hospital staff appreciate the influence of home and family factors on their patients.

Some Results

A number of recorded factors are available for periodic evaluation of the family health program. Records show, for instance, changes in the incidence of certain significant diseases, in the use made of health and medical services, in mortality rates and in the number of underweight babies. Changes in the environment such as the protection of the water supply, and an understanding of the etiology of disease—expressed in the adoption of healthier habits and a more enlightened approach to child care—attest to the effectiveness of the program's health education techniques.

One year after the introduction of the program, certain impressions were noted:

- The staff worked with new interest and at a higher standard. Nurses and sanitarians, engaged in a coordinated service with each other and with the doctors, developed a sense of responsibility and pride in their work.
- A low incidence of enteritis, represented a marked change over previous years.
- Routine immunizations were adequately carried out.
- A mutual confidence and respect had developed between the staff of the family health service and the people of the community.

Today's quick recoveries from mental illness effected by new treatment methods pose questions regarding the care of . . .

CHILDREN OF DISCHARGED MENTAL HOSPITAL PATIENTS

ELIZABETH K. RADINSKY
Director, Foster Home Division, Jewish Child Care Association of New York

HOSPITALIZATION of a mentally ill parent is one of the most frequent precipitating causes for placement of children in foster care. For example, diagnosed mental illness has been reported in 62 percent of the families of the children in the care of the Jewish Child Care Association,[1] a voluntary child-placing agency in New York City. In most instances, hospitalization of the parent, usually the mother, has been the reason for placement of the child. In recent years more intensive mental hospital treatment, including the use of tranquilizing and other drugs, has made for unexpected or accelerated discharge of many parents from mental hospitals. Our experience at the Jewish Child Care Association has led us to believe that the impact of these discharges on the children who have been placed in foster homes needs intensive study.

We are in a period of a changing emphasis in social work generally, broadening the scope of our concentration from the individual to the family as a unit. Those of us who do foster home placement have been influenced by this change and have been reexamining our thinking about the place of the parent in the life of the child who has been placed away from home.

There was a time in foster care, not so long ago, when foster home placement was regarded as a panacea for children's problems. We regarded separation from the "highly questionable" family to be the best solution for the child who had been exposed to social pathology, mental illness, or both. We may have been aware of the manifold reasons—including excessive feelings of guilt or inadequacy—that contributed to his parent's withdrawal from parental responsibilities, but we felt no responsibility to the parent to help him handle these feelings. We either actively and deliberately discouraged the parents from visiting the child whom we had placed in foster care or, if the parents themselves did not sustain contact with the agency or their child, we made no effort to bring them back into the child's life. We overlooked then what we are now realizing sharply and clearly—that for the child the parent is present whether or not he is actually on the scene.

Despite the changing focus in our work with parents, we were still not ready for the dramatically sudden discharge of mentally ill mothers from hospitals which began to occur a few years ago, nor for the resulting effects on their children whom we had placed in foster care. Experience in the past with children in placement precipitated by a parent's mental breakdown had accustomed us to expect that the prospect of the child's reunion with his family was slight and that the duration of placement would be long. Consequently, our initial reaction to the sudden discharge of parents from mental hospitals was one of concern for the child, lest his way of life in the foster home be disturbed and lest he be returned home prematurely. As practitioners we had to reorient and adapt ourselves to this new phenomenon with its impact on ourselves, the children, and our planning. The following, our experience with the Brown family, illustrates this point:

We were in the process of working with Mr. Brown on the need for a plan in regard to himself and his son Louis, age 8, who was living with a foster family. The reports from the

State hospital as to the likelihood of Mrs. Brown's recovery from her mental illness of 7 years' duration were repeatedly unfavorable. In the course of our planning, we interviewed Mrs. Brown's mother and learned of a plan for discharging Mrs. Brown to her. This seemed so unlikely in view of very recent unfavorable reports from the hospital that we questioned the credibility of her statement. However, we subsequently learned that a 6 months' course of thorazyne treatment had resulted in such a dramatic change in Mrs. Brown that she was now ready for discharge. Even before we had word from the hospital about this, Louis' father told us, rather fearfully, that he was expecting his wife home.

Mrs. Brown's discharge was one of a succession of similar discharges which catapulted us into recognizing that mentally ill parents were no longer to be discounted, but had to be reincorporated into our total concept of work with the child and his family.

Almost always, discharge of the parent from the hospital is closely followed by a request for discharge of the child from placement. Often the child, at the time of placement—and for a long time afterwards—showed signs of deep emotional disturbance himself—the effects of having lived with a psychotic parent and of the kind of family disruptions that occur in families with a mentally ill member. Louis Brown had shown such signs:

Louis Brown had come into the care of the agency when he was 5 years old, after 3½ years of being shunted between the home of his nervous, highly strung, overprotective widowed maternal grandmother and that of his maternal aunt. In his aunt's home there was constant quarreling and bickering among the adults as well as conflict between Louis and two older cousins.

Mr. Brown, a depressed, diffident individual who had been brought up in an institution from infancy because of the hospitalization of his mentally ill mother, became concerned with the disturbance his son was showing. When he learned that the prognosis for his wife's recovery was unfavorable, he insisted on his child's placement in foster care despite the determined opposition of his wife's relatives.

Louis, extremely shy and fearful, suffered from stuttering and a constant, hacking, nervous cough. Initial psychological tests indicated that he was intellectually superior, but had inner fears and anxieties which were affecting his mental functioning. His first year in placement was difficult, but the following 2 years brought steady improvement. Gradually he showed less evidence of having fears; he acquired friends; he became able to assert himself with his foster parents and foster brother and he became a leader in his class.

Louis' maternal grandmother, an important person in this family, exerted a controlling, domineering, and destructive influence on Louis' mother. When Mrs. Brown became accessible to treatment, the hospital tried to help her become more independent of her mother, but did not succeed. An added stumbling block to these efforts was Mr. Brown's passivity.

Even after discharge, Mrs. Brown was guarded, suspicious, fearful, and uncommunicative. Both she and her mother regarded her discharge from the hospital as a sign of total cure and readiness to care for Louis. Despite our agency's attempt to work with Louis' grandmother during Mrs. Brown's hospitalization, she continued to regard us as the authority responsible for her daughter's continued hospitalization and, through the child's placement, of her son-in-law's freedom from responsibility.

Mr. Brown, who received intensive casework treatment after the child's placement, had slowly achieved trust in the agency's genuine concern for his child and himself. He had begun to take a more active role as a father. Although he could not withstand the combined pressures from his mother-in-law and wife sufficiently to be able to defer asking for the boy's return, he was able to participate in the planning for this with the caseworker. This allowed a span of time after Mrs. Brown's discharge from the hospital before the child's return home during which the mother could visit the boy for gradually lengthened periods of time in his foster home, and he in turn could make weekend and holiday visits to his parents. Thus Louis had an opportunity to become acquainted again with his mother before he went to live with her, and Mrs. Brown had a chance to try, with the caseworker's help, to become accustomed to the fact that the infant she had left behind when she was hospitalized was now an 8-year-old boy.

After Louis returned home, his caseworker continued to work with the family for a year even though Mrs. Brown was as suspicious of her as ever. Because of Mrs. Brown's suspiciousness, the caseworker's contacts with Louis had to be in her presence, an arrangement that was frustrating to the child. In the foster home he had been allowed time with the worker alone, and was well aware that the worker also had individual interviews with each of his foster parents and with his own father.

Mrs. Brown also frowned on the worker's having separate interviews with Mr. Brown. For her, the supervision provided by the agency in the interest of her child was an evil to be lived with—the price of having her child discharged to her.

Louis' area of continuing gratification was at school. He learned, to a degree, to circumvent and control his mother as she repeatedly tried to impose her fears on him. He accepted his mother's prohibition against having friends visit him at home and he developed a technique of ignoring his mother when she encountered him with his friends on the street. When he was supposedly at the library, he was actually in the park playing with his friends. During Open School Week he arranged for his mother to visit in the classroom and for his father to come for a conference with his teacher. He did not ask to visit his foster parents, but did manage, with his father's help, to communicate with them.

On the basis of our analysis of Louis' needs and our understanding of the family situation, we would have preferred for Louis to remain with his foster family until he was 2 or 3 years older. This would

have given him further opportunity to utilize the good environment of the foster family and the agency's treatment services to free untapped potentialities which had been dammed up by his earlier traumatic experiences.

Long-time Care

Some situations call for the protection of children in foster care for the duration of their childhood. However, even in these situations the parents have significance for the children, and the family as a whole for each member of it. We have sometimes found it necessary to control and supervise the parents' visiting of their children by having the visits held, by appointment and, in the presence of the caseworker, in our office. Even so the visits become something of a family get-together.

Some parents can be helped to accept a curtailed role as parents for the sake of their children as well as for themselves. They learn to understand that the agency has to take on the child rearing responsibilities as well as treatment to give their children as much opportunity as possible for corrected development and growth. Many parents who did not in their own childhood have the opportunity for healthy personality development want it for their children and can participate, in varying degrees, in a plan to let them have it. Such parents were the Stones.

Sam, the oldest of the three Stone children, aged 7 to 15, told us that his father had called him to announce that they would be going home because the mother had been discharged from the mental hospital. The Stone children had been placed in foster care by us 3 years before, their placement precipitated by their mother's hospitalization.

Mrs. Stone had never been equal to the responsibilities of motherhood. She had remained in bed most of each day, neither bathing her children nor preparing food for them. Mr. Stone, a man with a dependent, immature personality, also spent most of the day sleeping because he worked at night. The two older children were sent to the maternal grandparents on awakening. The youngest was kept tied in the crib each day until the father awoke and took him to the grandmother's home.

Held responsible for his wife's condition by her family, Mr. Stone had resigned himself to this pattern of living until his wife had an acute psychotic episode. This episode precipitated the placement of the children in foster care, but by then they were so severely disturbed that no foster family home could contain more than one of them. They were therefore placed in different families. In addition, each required psychiatric treatment, which was arranged for by the placement agency.

Immediately after the mother's release from the hospital, Mr. and Mrs. Stone demanded the return of their children. This was not surprising since they had regarded the mother's hospitalization as the reason for the children's placement. The agency and the hospital's after-care clinic were united in letting the parents know that returning the children home would involve grave risks to both the mother and the children. Mr. Stone was encouraged to withstand his wife's pressure for the children's discharge from the agency and agreed to a plan of continued foster care for them. The children were helped to understand and to accept the nature of their mother's illness and their need to remain away from home. During the parents' visits to the children, the worker's presence tempered the interaction of children and parents, to the benefit of all.

In this case if we had not been able to establish sufficient rapport with Mr. and Mrs. Stone to keep them from pressing for their children's return, we would have considered it our responsibility to take legal steps, with the support of the after-care clinic, to prevent the children from being returned home and to keep them in foster care.

Seeing the Family Whole

The following experience provided us with a serious lesson in the importance of diagnosing the family as a unit.

The Rose children, 3-year-old Jane and 22-month-old Paul, had been placed in foster care at their father's request at the time of their 28-year-old mother's third attack of mental illness. In the history of violent marital discord that preceded Mrs. Rose's mental break, Mr. Rose had played a significant role but casework efforts with this youthful, immature father during the year of his children's placement did not appreciably alter his failure to comprehend his share in the responsibility for the disturbed relationship in the family, or the implications of his wife's illness.

After receiving drug treatment and psychotherapy in the hospital, Mrs. Rose was remarkably improved. Being home from the hospital, albeit on convalescent status, meant to her having the children again with her. Therefore, she and her husband immediately pressed for the children's return to them. Both the medical and social service staff of the hospital and the representatives of the agency, in joint conference, recognized the fact that returning the children involved a risk. But the psychiatrist who had treated Mrs. Rose pointed out that "being the mother" had been the prime motivation in her recovery. Consequently, a family service agency was enlisted to provide the Rose family with a specially selected homemaker, while our agency, as the agency which had worked with the children and their father during placement, continued to visit the children regularly after they returned home. To avoid confusion for the mother, the family service agency agreed to let the foster-care worker supervise their homemaker.

Despite the coordinated efforts of the two agencies, it became increasingly apparent in the following 3 months that these children should not remain at home. Mrs. Rose was unable to function as the mother but would not let the homemaker substitute for her in this capacity, even in giving the children their meals. She would not take the children to the playground and would not permit them to go with anyone else. The homemaker left, since she was not permitted to be helpful, and the situation worsened.

In bursts of uncontrollable temper, Mrs. Rose would beat little Jane, who had become angry and destructive in the brief period since she returned home. Paul was no longer the happy, smiling baby he had been in the foster home; and the father neither carried his own responsibility in the home nor in any way offset the effects of his wife's disturbed behavior on the children.

Since Mr. and Mrs. Rose refused to consider voluntarily placing the children again, our agency, with the hospital's support, enlisted the services of the children's court to bring the children back into placement. In a joint interview with the hospital social worker and our worker, the parents were advised that the court was being brought into the case for the protection of themselves and their children.

By letting the parents know in advance of this plan and the reasons for it, we were able to avert their opposition to it and at the same time convince them of our concern for the entire family.

In this case we lost sight of diagnostic data important to definition of the family as a unit. The great improvement of the mother during her hospitalization, attributed in large measure to her expectations of resuming her role as mother, had dimmed our awareness of her history of basic personality disturbance and recurring mental breakdown. Caught up in the desire to help the children through reunion of the family, our agency had permitted our doubts about how this would work to be submerged in the hospital's explanation of the motivation in the mother's improvement.

As a visiting father and a visiting husband, Mr. Rose had been concerned and responsible. In his own home, however, he had failed in his everyday responsibilities. He had been ineffectual as a husband and father before the children's placement and after their discharge. He could not accept the implications of his wife's illness nor could he comprehend the risk to his children of the family's premature reunion.

Mr. and Mrs. Rose needed time to live together as husband and wife before assuming the additional responsibilities of parenthood. Our agency, with the support of the hospital, should have made this clear to the couple, for their own as well as the children's sake.

With the children back in foster care, it is now our task to help these two young people who want to be good parents, but are caught in a struggle with their own individual problems and with their relation to each other.

Knowing the Family

The child-placing agency is handicapped in grappling with the question of whether a child should return to a parent recently discharged from a mental hospital, because it does not usually know the family as a unit. Often the return of a child's mother from the hospital affords the placement agency its first opportunity to meet her, since the actual planning for placement may have occurred after her hospitalization. There are, fortunately, guides that can help us build such a picture from the parts we do know. We have had the opportunity while the child was under our care to get to know him and his needs. We have seen the father as a visiting parent and know something of the quality of his fatherhood from the degree of concern he has demonstrated and from the way he has met his specific responsibilities in connection with the child and the agency.

Usually we must rely on the hospital's diagnostic findings for our knowledge of the mother, but we can supplement this by meetings with her in our office or at her home after her discharge and by observing her behavior and her attitudes toward the agency and toward her child during her supervised visits with him while he is still under foster care. Later, planned visits of the child to his own family for brief or overnight stays, depending on the age of the child and his understanding of the meaning of the visits, can contribute further diagnostic and prognostic clues. Thus on the basis of what we learn from our own observations and what we can learn from the hospital after-care clinics, we must make a diagnosis of the family unit in order to reach discharge plans that will be sound for each child.

In some families such plans may have to be different for each child. What might be good for one child might be bad for his brother or sister. The case of Morton and Ann White illustrates the significance of differential diagnosis within the same family.

The White children were admitted into care at the age of 7 and 3, respectively, to make possible their mother's voluntary admission to a private mental hospital. This came after the family had received a year of casework help from a family service agency to which the parents had first gone because of Morton's disturbing behavior. These parents, young people of good intelligence, had both grown up in homes from which their mothers were absent because of mental illness. Neither was prepared for the responsibilities of marriage or parenthood. Almost as soon as Morton was born, a year later, they took divergent attitudes toward him. The father was punitive and hostile; the mother overprotective and inconsistent. Neither was able to provide him a nurturing emotional environment.

On the other hand, their attitudes toward their second child, Anne, born 4 years later, were harmonious and in sharp contrast to their attitudes toward Morton. Both gave Anne the

kind of tenderness and warmth which they had not been able to give to Morton.

Because of the different kinds of experiences these children had had at home and the important differences in the parental relationships to them, we made the decision to separate them while they were under our care. Morton was placed with a foster family chosen especially for its capacity to tolerate and care for a deviant child. Anne was placed in a regular foster family home.

Mrs. White returned home 10 months after the children were placed. At the placement agency we called together her psychiatrist from the hospital, the psychiatrist who in his private practice was treating Mr. White and our own psychiatrist who was treating Morton. The plan that evolved from this conference was discussed with the parents, and agreed to by them. This was first to allow the parents a period of readjustment without the children; and then to return Anne to them, but to postpone Morton's return, probably until he was past adolescence.

The plan to postpone Morton's discharge was based both on his own needs and on the fact that Mr. and Mrs. White needed more therapeutic help before they could be equal to the difficult responsibility of having him at home.

Morton was relieved to hear that he would remain with his foster family and was able to express his fear of trouble and unhappiness if he returned home. Although he has since made progress in his behavior and in his relationships, he is not yet able to cope with the problems in his family. He enjoys visits with his mother and on some visits he tolerates his sister. Sometimes he asks for visits with his father and at others he rebels against seeing him.

In Conclusion

In our work with children of the mentally ill and with their parents, we are still seeking a balance between our responsibility to the family as a unit, of which we are increasingly aware, and our responsibility for the child as an individual. We must come to terms with our recognition of the significance to the child of his own family, for which there is no true substitute, and our awareness that there are some families that without help cannot provide a healthy environment for their child.

We know from experience that there can be considerable risk in reintroducing into a child's life a parent who has been seriously mentally ill. Caseworkers must be alert to their own feelings in this regard. If they want to serve the child well they must examine the facts and implications of the patient's improvement or recovery in light of the known strengths and weaknesses of each member of the family and of the family as a whole.

Although a placement agency such as ours does not have the legal authority to prevent the discharge of a child from its care unless the evidence warrants court action, we are socially and morally responsible for helping a family recognize the risks, when we see them, in taking their child back home. The mental hospital, on its part, has a responsibility for helping the patient and his family to see the implication of the patient's return home, in relation to his family, the role he expects and is expected to assume, and how much of it he is capable of assuming. The child-placing agency also has to take the mental hospital's evaluation into account when planning to continue to keep the child separated from his family, even temporarily. When the child is returned home, the agency must be responsible for helping him become reintegrated into the family, either by continuing to give him service or through enlisting another agency to work with the family as a unit.

There is one final dimension to this problem which our profession must not ignore. A placement agency that carries the responsibility for the day-to-day care of children has both the opportunity and the obligation to provide treatment for children who show the effects of living with mentally disturbed parents. Our experience has demonstrated that casework services, supplemented by a range of remedial services, can arrest or reverse the destructive effects of an earlier environment of mental and social pathology. Only if the children of such families receive the protection they need and the services that can help undo the harm that their emotionally traumatic experiences have done them can we hope to break the chain of recurring mental illness from generation to generation.

[1] Federation of Jewish Philanthropies: To serve children best—a study of children in foster care. New York, 1956.

Mobility can be a great asset for the well prepared. It can be the trigger of tragedy for those unprepared to utilize their talents.

James T. Vocelle, Chairman, Florida Industrial Commission, to the 1960 White House Conference on Children and Youth.

A recently completed Chicago study reveals some facts about . . .

REHABILITATIVE POTENTIALS OF FAMILIES ON ADC

ANNIE LEE SANDUSKY
Consultant on Children in Their Own Homes, Children's Bureau

A UNIQUE STUDY of the aid to dependent children program which has significance for the entire public welfare field and particularly for child welfare has been completed in Cook County, Ill. The study grew out of the concern of the board of county commissioners over the mounting costs and criticisms of the program. The commissioners were baffled by the fact that the number of recipients was increasing at a time of economic prosperity; they were concerned because the number of illegitimate children on the rolls was increasing; and they were aware of allegations that many families were receiving ADC who were not eligible. Therefore, they selected a committee of 35 leading citizens to undertake a study of the program. This committee was representative of business, industry, the professions, the press, and the commission itself.

After a period of preliminary study and investigation, the citizen's committee hired Greenleigh Associates, a firm of management consultants specializing in the health and welfare field, to make an independent study of the ADC program, operations, and administration in Cook County. The study was financed jointly by Cook County, the Illinois Public Aid Commission, and the Bureau of Public Assistance, U.S. Department of Health, Education, and Welfare.

A research team representing a number of fields of learning and specialties was brought together by Greenleigh Associates to conduct the study. This consisted of specialists in social research, administration, and personnel, as well as sociologists, psychologists, economists, lawyers, and social workers. These persons worked independently on certain phases of the study or as teams on other aspects.

No part of the study was unrelated to other parts, but for convenience it was divided into six major portions:

1. Analysis of comparative data on the ADC program from 12 other metropolitan areas experiencing in-migration.
2. Appraisal of the statutory basis of the program and of residence and other laws affecting ADC.
3. Evaluation of the administration and operations of the ADC program in Cook County.
4. Analysis of the characteristics of the ADC families and the interrelation of these characteristics.
5. Availability of supportive community resources—public and private.
6. Appraisal of social factors in the community affecting ADC.

Although these parts were largely interrelated and that which we learned from one shed light on other parts, they were carried on almost simultaneously because the time allotted to the study was brief.

Some of the most important results of the study were:

• The findings showed the fallacies in some prevalent misconceptions about the administration of the program and about ADC families, such as ideas that

most of the families were newcomers to Chicago who had come for the purpose of getting ADC, that many fathers who were reported as deserting were in the homes, that unmarried mothers had children in order to increase their ADC grants. These misconceptions were found to be interfering with the administration and operation of the program and with adequate financing by the legislature.

- It was learned that to know how a large program of this type is operating, it is necessary to have direct and structured interviews with the recipients instead of relying on case records. Case records were found to be inadequate and frequently inaccurate.
- The families on ADC in Cook County were found to have a high rehabilitation potential which was not being realized.
- Because the Chicago ADC staff is on the whole overburdened and without professional training, the caseworkers frequently fail to identify problems which caused dependency initially and which impede rehabilitation.

Rehabilitation as perceived by the study staff means something more than physical or vocational rehabilitation. It means helping the family to identify and resolve their problems, so that they may become independent or more nearly independent of financial assistance. It means helping the family to improve their physical or emotional health or interpersonal relationships, so that they may live more normal lives, even if they cannot become self-supporting. It means helping to reunite families wherever possible. It means helping parents to give better care and understanding to their children so that they, in turn, may have a more normal life, develop their capacities to the maximum, and achieve personal and economic independence. It also means helping the mother who should not work outside the home see how ADC can help her remain at home and provide her children with the care they need.

Family Characteristics

This article will discuss some findings in the section of the study concerned with the attitudes and characteristics of the families on the ADC rolls at the time of the study and the administration of the program as it affected them. The purpose of this section was to ascertain the strengths and weaknesses of the families, to assess their rehabilitation potential, and to determine what were the factors which most frequently created dependency and which impeded a return to independent functioning. Information was gathered on each family's housing, residency, composition, income, employment and educational history, and attitudes toward employment, dependency, and illegitimacy. In addition, assessments were made of the family's management, child care and training, and emotional and physical health. The information was obtained from the case record and from intensive interviews with the family members in their homes, the latter proving to be the more productive source. The analysis of the data included an assessment of the interrelationship of significant characteristics.

Twenty-two case analysts who were professionally trained and experienced social caseworkers were employed to secure data from a random sample of families on the ADC roles. The sample included 1,103 families, more than 4 percent of all those receiving ADC in May 1960. Of these, 1,010 families were visited. The remainder were dropped from the sample because the case was closed, the family had moved and could not be located, or the grantee could not be interviewed due to illness or other reasons.. The cases in the sample were analyzed in order to determine family strengths and weaknesses and the potentiality for rehabilitation. It is this part of the study that is reported here. The total study has now been completed and the full report can be secured from Greenleigh Associates.[1]

Training and Data Gathering

In the 2-week training period for the case analysts, the main emphasis was to clarify the difference between the use of the interview in the casework process to help the client and the use of an interview to achieve the purposes of the research design. It was pointed out that in the research project, social work knowledge and skills are used to help the client give the information required to carry out the purposes of the study—a different process from the interviewing that is focused on helping the individual resolve his personal conflicts and problems. The case analysts were instructed to suggest to individuals who ask for help with their personal problems that they talk this over with their caseworkers from the Cook County Department of Public Aid.

Each family to be interviewed was sent a letter of notification about the impending visit. The letters had the threefold purpose of protecting the dignity of the families, giving them a sense of participation, and identifying the case analysts. Because of frequent turnover within the agency, ADC recipients frequently did not know their caseworkers and there-

Not all families in the aid to dependent children program are headed by mothers. This disabled father is one of many who has been helped by ADC to keep his family together.

fore the study staff had been worried lest the clients would confuse the case analysts with the agency's caseworkers. The letters, on official stationery of the research firm, explained the fact that a study was being made, outlined its purpose simply, and identified the sender as an employee of the firm. The client was asked to telephone if the time set for the interview was not convenient for him.

The approach to the client was also stressed in the training program. Because of the personal nature of the requested information and its relation to ADC eligibility requirements—such as amount and source of income, and the whereabouts of deserting or putative fathers—the case analyst was to point out early in the interview that no information he received would be revealed to the agency. The recipient was to be told that the information he gave would be put together with information given by other recipients in a report, but that no one would be identified in this. The research firm had made an agreement with the study committee and the agency that no information supplied by the persons in the sample would be revealed to the agency in any identifiable manner.

The training program also included a discussion with the case analyst of attitudes toward illegitimacy in an effort to help him in bringing this subject up during the interview.

An interview outline and schedule for the home visits served as a guide to the case analyst in securing information in the home so that there would be uniformity in method and type of material secured. Having read the case record in the district office before visiting the family, the analyst already knew something about the family when he arrived at the home.

The attitude of the ADC recipients toward the study was a surprise. The study staff had been afraid that the recipients might be suspicious of the case analysts and therefore resistant to talking frankly. None of these fears were realized. The recipients readily saw the distinction between the case analysts and the agency's caseworkers. Many of them expressed pride in having been selected to participate in the study and curiosity about the method of selection, and asked, "How was I chosen?" They clearly wanted to give information and to talk about their problems. Out of the entire sample, only two persons declined to participate. They were not urged to do so.

The majority of the recipients showed a sense of responsibility when they could not keep the appointments, telephoning ahead of time to make a change, or if they were not at home for some reason when the case analyst visited, calling later for another appointment. Some recipients misunderstood the letter and came to the study office to be interviewed.

Rating Method

The completed interview schedules were used as the basis for the analysis of the potentialities for rehabilitation of the families in the sample.

Each schedule was rated on whether or not problems existed in certain areas of the family's life and whether or not there were indications of potential for resolving them. The factors considered were: (1) the employability of the grantee; (2) the possibility of additional income to the family from an absent father or other children; (3) health; (4) child care and training; (5) family management; (6) family disunity; and (7) attitudes toward illegitimacy.

Some of the major factors were divided into subfactors. In employability of the grantee, the following subfactors were rated separately as a method for obtaining the factor's overall rating: attitudes toward employment; health; experience; training; and child-care arrangements.

In determining a rating for attitudes toward illegitimacy, the case analyst took into consideration: the number of children born out of wedlock; the number of fathers in the same family; the length of time of the relationship between the mother and the father; the age of the last child born out of

wedlock; the mother's attitude toward having a child born out of wedlock; what she had tried to do about it; and the degree of interest of the putative father in the mother and the children.

The rating on child care and training was based on the case analysts' observation, when this was possible, of the physical appearance of the children, their relationship to each other, and their relationship to the mother or parents. It was also based on what the mother said about such things as: whether or not there were problems in dealing with the children and how she handled these problems; what she knew about their school adjustment; whether she visited the school; what arrangements she made for the care of young children when it was necessary for her to be away from home, and her knowledge and concern about where her older children were.

Thus, in all of the factors, the interrelationship of significant characteristics were assessed to achieve an overall score.

In rating each factor, where no problems existed a rating of zero was given; a problem with good potential for improvement was rated 1; and a problem with little or no potential for improvement was rated 2. Thus the family strengths and weaknesses could be measured. The sum of the ratings on the major factors gave an overall score for the family's potentiality for rehabilitation.

A total family score of zero through 3 indicated a very high and immediate potentiality for rehabilitation and self-sufficiency. A family score of 4 through 11 indicated the presence of serious problems but good potentiality for improvement with help. Families with a total score of 12 through 14 had many problems concerning which the case analysts saw little hope of rehabilitation.

The majority of these families received scores somewhere between 4 and 11. This means that they showed good potentiality for the strengthening of their family life and for using help to achieve self-sufficiency.

Strengths in Child Care

The strengths the majority of these middle-scoring families showed were in relation to child care, training and adjustment, family management, and health, physical and mental. They had problems in these areas but ones with high potential for improvement. On the whole, these mothers gave good care to their children. They showed concern about their welfare and seemed to have hopes for their future.

Many of the families had no problems in relation to child care and training or in family management. However, nearly all of them faced a problem common to most children on ADC—the lack of a father in the home. Some of the mothers expressed worry about the effects of this lack on their children. The eligibility requirement that the parent be absent from the home unless permanently and totally incapacitated discouraged family unity in some cases.

The strengths these families showed in child care is of vital importance when considered in relation to the purpose of the ADC program—the welfare of children. The child's experiences in family living and the quality of care, training, and guidance he receives determines to a great extent the kind of adult he turns out to be. When the great handicaps these mothers were enduring in day-by-day living are considered, the tremendous job they were doing becomes evident. Most of them had to be both mothers and fathers to their children. Though they lacked the emotional support, cooperation, and companionship of a husband, they were managing on less than the minimum income considered necessary for health and decency. Their housing conditions were deplorable and their neighborhoods vicious and degrading.

For the total study, 38.6 of the mothers were not married to the "principal father"—the father of most of their children or of their last child if there were two fathers with the same number of children. Yet most such mothers gave evidence of loving their children. They either had no serious problems in child care and training or showed good potential for being able to overcome the problems they had, given appropriate casework service.

Contrary to general opinion, most of these unwed mothers expressed concern about having given birth out of wedlock, and their guilt, shame, and self-derision was expressed in many ways. In others a show of indifference may have been a defense to conceal their real feelings about this problem.

Some of the unwed fathers showed continued interest in the mother and her children. A flexible agency policy and the provision of casework help to both mother and father might have resulted in some stable marriages. For example:

Mrs. D, a widow with three children by her husband, has had three children born out of wedlock since the husband's death. Mrs. D and the children's father had made definite plans to marry and this was discussed with the caseworker. However, the father did not think he could support six children—three of whom were not his own, on his income. The

agency refused to supplement the income either by general assistance or by continuing ADC for the three children who were eligible and the marriage did not take place.

Employment Possibilities

In about half the cases analyzed there was little potentiality for employment. Yet most of the mothers said they wanted to work if adequate arrangements for the care of their children could be made. Many of them said they would take a job paying even less than their ADC grant, because, as one mother put it, "children want to feel proud of their parents."

The greatest problem in regard to employability was in arrangements for child care. Most of these families had no resources within the family for caring for the children if the mother were employed. Few child-care facilities were available in the neighborhoods where these mothers lived. Some of these mothers were needed at home all day because of the ages or number of their children. Many said they would worry about the supervision of their adolescent girls and boys if they were employed. Community facilities for the after-school supervision of adolescents were even more scarce than facilities for preschool children.

Lack of employable skills and work experience was a major impediment to the employment of many of these mothers. With vocational training some of these mothers could probably achieve self-support in the immediate future, while others could be prepared to go to work when their children were no longer eligible for ADC.

The majority of these families had no potential for achieving additional income from fathers or older children. In a few families the father was contributing already, was dead, or was receiving disability assistance, and there were no older children from whom income could be expected. In the majority of families the whereabouts of the father was not known.

In well over half of these families there seemed little chance of rehabilitation through the reunion of separated spouses or the marriage of unwed parents. On the other hand, in some of the families there were indications of some possibility that the parents would attain reunion or family stability, such as the father's continued interest in the children, the parents' own efforts to try again to "make a go of it" (although many of these efforts had failed), or the continuing relationship of the unwed mother and father of several children. In some instances, a previous and still legal marriage was preventing unwed parents from marrying. In others, the man's inability to get and hold a job was the reason given by the mother for not considering marriage.

Health

Less than 10 percent of the families with ratings ranging from 4 through 11 reported no health problems, physical or mental, to the case analysts. In the majority of the families there were problems of health that could be improved or controlled with adequate medical care. Others had serious health problems that were either chronic or offered little hope for improvement. Many of the incapacitated fathers were in this group.

More health problems were reported in the interviews than in the data taken from the case records. This may have been due to differences in the questions about health on the two schedules—the one for the case record being confined to chronic illnesses. It may also be that the families' infrequent contact with their caseworkers, the shortness of such contacts when they occurred, and the focus on eligibility determination keep them from mentioning health problems to their caseworkers or the caseworkers from inquiring about health.

Low and High Scores

Although the analysis showed that the great majority of the families came in the middle range of scoring, 2.8 percent had ratings that fell in the range of 3 and under, thus indicating a very high potentiality for eventually achieving self-sufficiency. They were families in which the educational level of the grantee was high school or above. The grantee had good training for employment in today's labor market, or good potentiality for training.

Most of these grantees had had work experience of at least 1 year or more before applying for ADC. Some were now employed and received supplementation through the program, and they had made, or would be able to make, adequate arrangements for child care. Neither they nor the children had major health problems. In these families the fathers were either already contributing to the support of the children or, because of death or disability, were permanently unable to contribute. Rehabilitation for these families could be effected on relatively short range goals.

Mrs. C, 23 years old, who is separated from her husband, has three children, 10, 7, and 3 years of age. A year ago she

and her husband attempted reconciliation but failed. Mrs. C is employed as a hotel maid and her wages are supplemented through ADC. Her mother lives with her and cares for the children while she is at work. In spite of Mrs. C's efforts, the family is not much better off financially than if she were not employed. Mrs. C buys clothing for herself and children on the layaway plan as do many other ADC mothers. The 10-year-old girl had to be kept out of school for 1 week last winter until the mother was able to buy shoes for her.

Is there enough incentive for a mother to work if she cannot raise her standard of living by so doing and at least procure the minimum essentials required for health, decency, and a suitable standard of living? If wages and supplementation—except for the expenses of employment—come to no more than the ADC grant, those who work are no better off financially than those who do not.

At the opposite end of the scale were the 3.8 percent of the families with overall scores ranging from 12 to 14. These families had serious problems in all or most of the areas studied, and low potentiality for improvement. The possibility of their becoming employed now or in the future is extremely remote because of their lack of skills and of experience usable in an urban labor market, their low educational achievements, limited mental ability, serious physical and emotional problems, and many children—five or more in each family. These mothers themselves saw no possibility of becoming employed.

In these families, care and training of the children were poor and in some instances actual neglect was evident. But in spite of their problems and limitations, most of these mothers were responsive to the case analysts. They will require support, guidance, and many services in helping them to improve the quality of care provided for their children. Work with them will have to be planned on a long-range basis, with the focus on the needs and problems of the children so that they at least may realize their maximum potentialities and break the family pattern of dependency.

In Conclusion

This analysis indicates that most of the families receiving ADC in Cook County have a good potentiality for improvement and rehabilitation, some on a long-range and some on a short-term basis. While many of the grantees themselves may never achieve financial independence, there is great promise for enhancing the opportunities for their children to receive adequate care, guidance, and training that will lead to their becoming independent, self-motivating, contributing members of their families and communities.

To accomplish this task, agency administration, structure policies, and rules and regulations must be geared to services. Many of the social services needed by such families can be provided within a public assistance agency if it has adequate and competent staff, smaller caseloads, good supervision for workers, and inservice training. Other services must come from other community agencies which provide health and medical care, vocational rehabilitation, psychiatric and child guidance services, child welfare services, day care, and other types of help.

The analysis of the home interview schedules reported in this article is only a small part of the total Cook County ADC study. The complete[1] report should be read for its full significance not only for Cook County but for the aid to dependent children program as a whole.

[1] Greenleigh Associates, Inc.: Facts, fallacies and future. New York. 1960.

It is not to die or even die of hunger that makes a man wretched. Many men have died. But it is to live miserably and know not why, to work more and gain nothing, to be heart worn, weary, yet isolated and unrelated.

Thomas Carlyle in Past and Present, *Harper & Bros., New York 1843.*

TOWARD SCHOOL ACHIEVEMENT FOR THE INSTITUTIONAL CHILD

R. ROBERT GEAKE
Graduate Student, University of Michigan, Ann Arbor, Mich.

WALLACE M. LORNELL
Resident Director, Methodist Children's Village, Detroit, Mich.

FOR THE LAST DECADE or two, many homes for dependent and neglected children have been sending their children to public schools in the community and have encouraged the children to participate in comunity activities. These moves have been made with a realization that children in group care need as many normal experiences as possible. At the same time, however, the number of children in group care who have school adjustment problems is increasing as the result of a change in the nature of institutional populations. With the growing realization that young children need to be brought up within a family group whenever possible, more and more institutions with a tradition of providing longtime care for young children are responding to requests for shorter term, more specialized care for older children and children too emotionally upset to get along well in a foster family.[1]

This change has meant that the institutional programs are tending to becoming more treatment centered than in the past when their chief function was to provide children with maintenance and care.

School achievement is a vital factor in a child's total adjustment. Many children in group care have a very poor concept of themselves. This self-perception is often improved when the child does better in school and receives better school marks. Our society places intrinsic values on school marks, and children come to equate these marks with real achievement and a measure of personal worth.

Many children in child-caring institutions today cannot adjust in public school either because of severe behavior or learning problems, or both. Consequently some institutions are introducing tutoring on the grounds for at least part of the populations. In a well-planned institution, such classes are geared for remedial work and do not keep children away from the public schools who are acceptable there.

However, much remains to be done for children living in residential group care who are able to attend public school. Many directors of children's homes have felt for a long time that children in their charge do not do as well in public school as their classmates from the community. A recent comparative study of school marks in one children's home confirms this impression.[2] In this study the report-card marks of children living in a children's home who attended four public schools in grades 2 through 9 were collected. Then children living in their own homes were found who could be matched with the institutional children in regard to intelligence, sex, public school attended, and grade level within each school. This study revealed that the children from the institution were underachieving significantly in all academic subjects, though they were performing better in nonacademic subjects, such as music, art, and physical education. Underachievement was defined as a failure to perform as well as would be expected from a child's measured intelligence and the achievement of comparable children.

Causes and Blocks

Some possible causes of underachievement of institutional children in public school include:

- **The community values and culture may be drastically different from the child's familiar surroundings.**
- **Academic school achievement may not have been considered important in the child's home.**
- **The child's school attendance may have been disrupted by frequent shifts between relatives and boarding homes.**
- **The child's emotional state may be characterized as acute anxiety with resultant learning blocks.**
- **The community and the school may be prejudiced against the "kids from the home" because they present problems to the teachers and principal.**

This last possibility was strengthened by Hadley's

demonstration of the fact that children who are less well liked tend to receive lower school marks irrespective of their actual achievements.[3]

A primary block to helping institutional children to better school achievement seems to be a general apathy in this regard among professional educators and social workers. This may stem from lack of appreciation of the meaning of school marks to children. In many institutions this kind of apathy is supported by the fact that the children's school achievement is nobody's specific responsibility. By default, the public school teacher, probably already struggling with the academic and behavior problems of several other children in her class, is left the task of identifying and stimulating the underachieving institutional child. She may begin the task of working with such a child with enthusiastic optimism, only to find as the weeks go by that little or no progress occurs. Then a sort of hardening of the emotional arteries may set in until even the normal current of academic and social stimulation between teacher and pupil ceases to flow.

Achievement is to be measured against potential, we are sometimes told, and the crude conveniences of A's, B's, C's, D's, and E's, though they must be tolerated, are not to be regarded as valid enough indices of anything to be worth doing something about. Even if this is true the plain fact remains that marks are important to children, and we can be of greater help to children if we recognize this. The report card is the "paycheck" of the school child. The development of ego strength may be directly related to school achievement, of which marks are society's symbols.

What Can Be Done

There are five prerequisites to academic learning, and these need to be assessed individually for each institutional child before he is placed in public school. The first of these is general intelligence and the rather specific abilities of which it is believed to consist. The institutional administrator in planning for the children's education ought, therefore, to insist on more than an IQ score from the psychologist. He needs to know about subtest performances and their implications for level of functioning both currently and potentially.

The second prerequisite is developmental readiness and potential. This includes physical maturation and also the fund of experiences on which the average child who lives at home can draw—experiences which the institutional child may have missed in the sequence of disrupting events that led to his placement. They include such ordinary events as trips away from home, conversation with adults, and opportunity to develop and execute one's own plans in play.

The third prerequisite is freedom from emotional tensions and anxiety blocking, conditions which make learning difficult or impossible for some children. Where anxiety and tension are great, energy which is normally available for learning may be diverted into dealing with emotional conflict. Among institutional children, emotional problems of long standing often continue to trouble the child long after placement in a treatment-oriented setting.

The fourth prerequisite to learning is motivation. The child is motivated to learn only as he perceives himself as capable of succeeding. Children vary in degree of motivation for learning according to their previous experiences of success and failure.

The fifth, and most significant, prerequisite for academic learning is the opportunity provided by an educational program which recognizes the child's needs and includes specific, planned procedures of academic stimulation.

Recognition of a problem is the first step towards a solution. Many modern child-caring institutions have recognized the need for casework service, including psychological and psychiatric consultation, to help the children with their emotional problems, and insist on qualified professional personnel to supply it. They are also taking steps to improve the quality of their child-care staff through the provision of inservice training courses and the improvement of salaries and working conditions.

But relatively few institutions recognize the need for professional educational personnel to help the children with their school problems. A creative educator, trained in special education and remedial work, can help the children directly by serving as a tutor. He can also provide consultation to the casework and child-care staff as well as to the administrator.

Several educational studies have demonstrated that homework in the elementary grades ordinarily has little value.[4-6] However, this does not necessarily apply to the child who lives in an institution and who, for various reasons, has missed some school experiences and is therefore one or more grades below his age level. A study of children at the Methodist Children's Village in Detroit who attend public school revealed that almost a third of them have had to repeat grades. Many children also cannot read

up to the level expected of the grade they are in.

With help from the house mother or tutor, children who are reading 2 or 3 years below grade level can be stimulated to improvement through specific planned techniques. Reading to elementary school children sometimes whets their curiosity for further reading or helps them understand what they have been trying to read. And, vice versa, encouraging the child to read to an adult with whom he identifies and feels secure can build up the child's motivation for school achievement.

We have found in the Methodist Children's Village that beginning with the junior high school level, a regular quiet study period of 45 minutes to an hour can be very conducive to learning, especially if the child-care staff has time to help the children during this period. This means that the staff must not be too encumbered with household chores. Efforts to coordinate the institution's recreational activities with the educational program so that they are not in competition with the study period are also important.

As in so many phases of the institutional program, the child-care worker is a key to the success of efforts to help children with their school achievement. If she is to be helpful in this, she must be sufficiently educated herself and have enough self-confidence to help children with their studies, and to ask advice of the educator when she needs it.

If the child senses a genuine desire to help him do better, he will lose interest if the staff's support and encouragement are allowed to degenerate into nagging. One way of convincing the children of the institutional staff's interest in them is for the staff to participate in community-school functions, such as PTA meetings and father-son nights. Staff discussions with the children's teachers about their progress encourages the teachers to take more interest in the children in spite of the frequent frustrations they encounter.

Equipment

Educational equipment can also be employed by institutions to stimulate and motivate learning. While many institutions recognize the need for adequate recreation and playground equipment, a modern kitchen, and appropriate health facilities, often they overlook the fact that educational toys and games are needed for use in the cottages where the children live. For example, blackboards can help stimulate children of elementary school age to play school. Bulletin boards make it possible for children to display their papers. Toy clocks with movable hands, word games, flashcards, counting games, dice and dominoes are all educationally stimulating as well as alluring to the child who loves games.

Wall maps, globes, and attractively illustrated books, newspapers and magazines—especially children's magazines—as a part of the normal home atmosphere can also stimulate children's intellectual curiosity. Radio and TV sets can provide the children with an opportunity to hear and discuss news programs which can be helpful to them in their social studies.

A set of recent encyclopedias is important for children above the sixth grade and helpful for children in lower grades as well. Sometimes institutions can get community groups to donate such items, particularly at Christmas time.

Institutions can also encourage more interest in nature and biology by providing plots of land for gardening, pictures of birds, small aquariums, and bird cages. Excursions and camping trips can be made more purposeful by more careful planning. Looking over maps, discussing the coming events over the dinner table, and reviewing objects to be observed on the next trip may bring the children an added joy of anticipation as well as broaden the experience for them. Boys scheduled for a trip to the ball park might be drawn into a discussion of batting averages, which might encourage them to figure out their own batting averages when they play their next ball game.

Children need encouragement and stimulation if they are to succeed in school. If these become an integral part of their normal daily living, the chances of resistance to them are lessened and of success increased.

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How the use of a pediatric team in a rural area helped health and welfare agencies promote . . .

COORDINATED SERVICES FOR CHILDREN WITH PROBLEMS

AUSTIN W. MATTHIS
Former Health Officer, Imperial County, Calif.

GWENDOLYN BECKMAN
Public Health Social Work Consultant

BELLE D. POOLE, M.D.
Child Health Consultant

California State Department of Health

IN ALMOST EVERY COMMUNITY, rural or urban, some families exist which are worn down by so many problems that they consume a large portion of the time of social and health agencies.[1] While these families have been known to the local agencies over the years, their histories are grim reminders of the tragedy in fragmentation, duplication, and delay in the provision of services and the absence of many types of services needed. This is especially true in the broad fields of health and medical care, for many such families discouraged by a lack of knowledge or understanding seek such care only in crises.

Three years ago a project was established in Imperial County, Calif., designed to solve three types of problems in the way of serving the children of such families more effectively. These problems were: (1) the need for expert diagnoses for children with health and behavior problems; (2) the isolation of agency services; (3) the need for community action to meet gaps in services.

Imperial County is a large rural county, chiefly sustained by agriculture. The county government provides the usual services of a health department, a welfare department, a hospital, schools, and a probation department attached to the court. As is usual in rural communities, these agencies did not at the time of the project have highly trained specialists.

A study of this area, completed just before this project began, showed that one-half of the families received an income of less than $3,000 per year, and over one-half of the unattached persons made less than $1,000 per year. The study also indicated that housing[1] and sanitation were major problems. Nearly one-third of the population were found to live in crowded conditions, one-third of the dwelling units having no inside toilets. One-fourth of the employed population in this area were farm laborers, many of whom follow the crops in California, but consider Imperial County as their home base.[2]

The Beginning

The process of agency cooperation in Imperial County had actually begun before the project was initiated. The health and welfare departments of Imperial County had maintained a close working relationship over several years, and had been coordinating their planning and activities in many fields where their interests overlapped. As a result of this relationship, various child health problems in the county had been identified and ways of eliminating them discussed.

The project itself was stimulated by a specific request. The county welfare department had asked the county health department to help secure physical examinations for children in foster homes.

A great many of the children in foster care were wards of the court, their parents having abandoned them or having been themselves institutionalized.

Both the health and welfare departments realized that many of these children would have problems requiring skilled diagnostic services. For example, a child of 14 months, waiting to be placed in a foster home, was not yet walking. Was the child's difficulty physical or psychological? What was the trouble with the 2-year-old who refused to eat solids and would drink milk only from a nursing bottle? Did the preschool child who had such extremely violent temper tantrums have a neurological problem?

Staff from both departments got together with consultant personnel from the State health and welfare departments to devise a plan. They reached an agreement that the diagnostic services could best be provided by staff from a medical center. The county's small understaffed public hospital, then with no outpatient department, was in no position to provide the service. Consequently, the county turned to a large teaching medical center 225 miles away, the medical school of the University of California at Los Angeles, to provide field service through an interprofessional diagnostic team. This was organized by a pediatrician, chairman of the school's department of pediatrics, who remained the project's coordinator and chairman. Actually an interdepartmental group from the medical school's departments of pediatrics, psychiatry, and preventive medicine, the team also included a pediatric psychiatrist, a psychologist, and a medical social worker. The cost of its services was met by three California State agencies: the State departments of health and of social welfare, and the California Youth Authority.

The Procedures

This team worked closely with two other groups: a local working group consisting of nurses from the health department, social workers from the county welfare department, school personnel, and probation workers; and a group of consultants from the three supporting State agencies.

A clinic session lasting a day and a half was held every 3 or 4 months. The children to be examined were referred by private physicians or by the local agencies—the health department, the welfare department, the schools, the probation department, or the county hospital. Several weeks before the clinic, the social, educational, and health histories of each child and the other members of his family were collected by the appropriate agencies, summarized by the health department, and forwarded to the diagnostic team for review and study. Urinalyses, tuberculin, and hemoglobin tests were performed by the health department on each child selected for clinic appearance before the team's arrival. The team confined itself to the examination of four children, or less, at each clinic session so that it would have time also to interview the foster mothers and, if possible, the child's own parents.

On the day before the clinic session, the psychologist tested each child. The session began with a review of the case materials by the diagnostic team and the local working group together, including information on any developments occurring after the case summaries had been prepared. These discussions brought an important educational byproduct to the local working group, whose questions were answered with care and skill by the visiting experts. For example, a simple yet comprehensive discussion of enuresis which occurred at one session will probably never be forgotten by the local participants.

Following the case review, each child was given a complete physical examination by the pediatrician. The child and his accompanying parent, or foster parent, or both, were interviewed individually by the psychiatrist or the social worker. Occasionally, depending on the age of the child and the nature of the problem, the pediatrician also interviewed the parent. Clinic procedures were adjusted to the needs of the individual case. The psychologist was routinely present during the group sessions, not only for testing but for the discussions.

After the examinations, the team reassembled, with the local working groups and the State consultants to summarize and discuss the findings and to make recommendations for necessary action. Decisions not only had to be made quickly because of the shortness of the diagnostic team's visit but they had to be grounded in the reality of available community resources and skill. Recommendations would be useless that could not be carried out by the local agencies. At the end of the session the social worker or the pediatrician from the team explained the findings to the foster mother or to the child's own mother.

Since its beginning 3 years ago, the project has broadened its focus from children in foster care only to include any child who is presenting problems to the local agencies, to the schools, or to his parents.

The following case of 13-year-old John, whose behavior had been disturbing the community, illustrates what this project means to a child.

John was referred to the clinic by the probation department because of a "strange" body build (long arms, big hands and feet, small head), possible

mental retardation, and behavior problems which had resulted in his expulsion from school. Complaints in regard to his behavior included alleged sex activities, laziness, temper tantrums, and lack of cleanliness.

John lived with his mother and two sisters. His father, a seasonal laborer, who had deserted them 3 years earlier, had a record of arrests and jail terms for nonsupport. The family was receiving financial assistance from the welfare department.

The examinations revealed no physical abnormalities, though the boy was physiologically immature for his age, and also showed normal intelligence.

In the ensuing discussion the agency workers seemed disappointed to learn that neither the boy's IQ nor his physical condition provided any explanation of his behavior problems. The discussion, however, established an authoritative foundation for further consideration of the boy's social history and of his family's social and emotional needs. The most striking contributions by the experts were their objective, unwavering focus on known facts, as opposed to hearsay, and their use of the discussion to provide a true learning experience for the participants.

Out of the discussion a plan of action developed, probably quite different from what most of the local workers had expected. This plan included: (1) resumption of school for John; (2) the provision of consultation, in regard to his condition, to the appropriate school personnel; (3) efforts to locate John's father, with the hope of reuniting the family; (4) finding John a recreation project under the leadership of a man with whom he might be able to identify; (5) helping John's mother to understand her son's behavior and also to understand and accept the proposed plan; (6) continued consultation from the diagnostic team to the various local agencies about problems arising in regard to the boy.

Responsibility for providing the consultation to the school personnel was assumed by the health department; for taking steps to find the father and for working with the mother, by the welfare department; for finding the appropriate recreational leader for John, by the probation officers.

Thus the local agencies were helped to take concerted action to guide this boy, who had seemed headed toward an institution, back into the normal stream of life.

Involving the Community

From the beginning, the plans for the Imperial County project included work with community. This was important in view of the hope that the project would one day be completely supported by local funds. Meetings with community leaders and the representatives of various local groups were held on the mornings following the clinic sessions. In addition to the staff members of the involved agencies, those invited to attend included the judge of the juvenile court, the representatives of the Imperial County Board of Supervisors, the superintendent of schools, the school administrators involved in specific cases, teachers, and the district school nurses.

The meetings were conducted on an informal basis in the judge's chamber in the courthouse, and in spite of the fact that they took place on a Saturday morning, there was always full attendance. The teaching team led discussions of problems of local concern and interest in relation to current knowledge of the principles of child growth and behavior and parent-child relationships, but not in terms of any specific child.

Among other subjects to come under discussion in these meetings were: the use of the foster family as a tool in working with children of disorganized, troubled homes; and the usual importance of keeping children of the same family together when foster family placement must be made; the strength of example, on the part of foster parents, in helping adolescent girls establish appropriate behavior toward the opposite sex; the importance of the foster father as an identification figure for the adolescent boy; the strong possibility of future delinquency in an aggressive child from a disturbed home who exhibits behavior problems at school; the place of firmness rather than force in helping the disturbed aggressive child to learn more acceptable behavior.

These meetings often brought to light misconceptions of agency function and sometimes unexpected support for the provision of additional service to fill gaps which became obvious as the discussion ensued. In one meeting the director of the local welfare department referred to his difficulty in establishing a child welfare service. The judge immediately announced that he would have backed efforts to establish such a service if he had known the need existed.

Since then the department has been enabled to employ two child-welfare workers. Other developments in the community which have occurred in the 3 years since the initiation of this project also were accelerated by its effect in highlighting specific community needs. These have included the initiation of an adoption service in the welfare depart-

ment; the addition to the court of a conciliation service and also a marriage-counseling service; and the establishment of a training project for foster parents, carried out by the State and county welfare departments.

In addition to these developments, a case committee composed of representatives of the same agencies which participated in the diagnostic program meets regularly to develop more effective interagency procedures and plans. The case committee grew out of the discussion of an interagency procedural problem between the school and probation departments, involving a truant adolescent.

The participating agencies are now discussing jointly and within their own staffs ways in which they might work to prevent children from having the kind of problems which bring them to the community's attention. Agency representatives meet with community groups from time to time to discuss the project, and in doing so have created a growing interest in prevention. The type of questions which now come up in the discussion meetings following the clinic are: What factors in the community foster the well-being of its citizens? What are the prevalent attitudes toward minority groups and how do these affect children in growing up? What other community attitudes make it difficult for children?

Reciprocal Advantages

In addition to the advantages provided the children, the stimulus for coordinated services provided the local agencies, and the remarkable opportunity for education provided to the local agency personnel and other members of the community, the project has brought advantages to the sponsoring State agencies and the university medical center which furnished the diagnostic team.

Generally speaking, consultation from State departments to localities tends to be an independent operation because of the structure of the State agencies and the specialized nature of their various responsibilities. This is not due to lack of interest in coordination on the part of the consultants, but to the specific program policies, the departments' patterns of relationship to local areas, and differences in their priorities. In spite of overlapping interests, it is very difficult for large departments to coordinate their consultation services.

Since the initial impetus in establishing this project came from local cooperating departments, coordinated consultation from the three interested State departments became a necessity. Therefore, field consultants assigned to the area by the State departments of health and of social welfare and by the California Youth Authority have attempted to interrelate their consultative activities by discussing their plans together. They have also established a routine of preparing joint field reports relating to their work in Imperial County.

The project provided the diagnostic team from the medical center with an unusual opportunity to observe the health and social problems of a small rural community, the functions and overlapping interests of its various public agencies, and the kinds of resources that are available or lacking to meet the needs of the families and children who are in trouble. This firsthand observation enabled the team members to carry back to their medical students a realistic picture of what practice in a rural community can mean, the kinds of problems which can arise, and the kind of help which can be given even when highly specialized facilities and services are not available locally. It provided them with a wealth of case material pointing to the importance of the team approach to diagnosis, of coordination in the provision of services, and of a coordinated look at the entire family when planning service to a child.

The clinic demonstration lasted for 2½ years. At the end of this time the group from the university medical center recommended that a similar group be established on a permanent basis within the county for carrying out a continuous program. The county board of supervisors accepted the recommendation. As a result the Imperial County Health Department now has on its staff a certified pediatrician as MCH director, and a social worker, as well as a position for a psychologist. The local maternal and child health program has been completely reorganized to provide continuous health supervision and medical care for those families under their care. In addition, it is sponsoring, along with the School of Medicine of the University of California at Los Angeles, a research project in the area of family disorganization, with the hope that this may lead to new methods of service and also bring into focus definite areas of prevention in the field of maternal and child health.

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CASE CONFERENCE

IN LINE WITH ITS GOAL of stimulating interprofessional communication and understanding, CHILDREN with this issue presents its first "case conference," a feature to be repeated with varying cast and story from time to time.

Ever since the establishment of the old "charity organization societies" at the end of the 19th century, "coordination of services" has been a phrase increasingly used by persons engaged in helping people. Still too often the phrase is only a theoretical goal. The following case, taken from actual records, illustrates the tragedy of this. The comments bring the perspectives of a variety of professions to the question of how the situation described might have been avoided and what steps need to be taken from now on.

Readers are invited to contribute to the discussion of this case and its accompanying commentaries through the "Readers' Exchange" section of subsequent issues of this journal.

Whose Responsibility?

Mrs. A was admitted to a State mental hospital in 1958 after having walked out of her house in a small urban community 2 to 3 weeks prior to admission. She left her husband and three young children uncared for. Her husband, a plumber, had to make some arrangements for the care of the children, so he asked his 65-year-old grandmother to care for them in his home. He said, "She did pretty well but she's kind of old and it was hard for her to care for such young children." He was working long hours, often from 7 a.m. to late at night if emergency plumbing installation was necessary. Unless he did the extra time he would be fired. Later he reported, "Because I had to get to the hospital to see my wife and help my grandmother with the children, I kept asking my boss for time off and was soon fired. Then I just stayed at home to care for the children until my wife came back from the hospital 6 weeks later. I was able then to do some outside painting until the cold weather came. Since then I have been receiving unemployment compensation, but it will soon be used up."

Six months after Mrs. A's discharge from the hospital, a visit was made to her home by a research social worker making a study of the care of children whose mothers are hospitalized. The research social worker had already seen Mrs. A once in a hospital. Mrs. A was found sitting at the kitchen table crocheting. She was obviously pregnant, a fact that had not been noted in her hospital record nor mentioned in the prior interview with the research worker. Sitting with her was Tom, her 2½-year-old son, whose face was dirty and whose nose was running profusely. Mrs. A started by saying, "Things have really been tough since I last saw you, particularly because my husband can't find a job anywhere, although he goes out practically every day looking for one." She explained that he had just left to look for a job in a local store since he had a lead that there might be one. In a few moments he returned saying there was no job available.

Mr. A explained that he had been "all over the place looking for a job and to nearby States, but I can't find any work. I'm getting worried because my unemployment compensation of $37 a week runs out in a few weeks. And now we have more trouble because my wife is 7 months' pregnant, and she hasn't even seen a doctor yet. Last week I tried to get a doctor because she was having some bleeding. I called six doctors and explained that I was out of work for several weeks so I didn't know how I could pay the bill, but my wife was 7 months' pregnant, was having some difficulty, and needed a doctor. Three doctors said they weren't taking maternity cases any longer; one said he was too busy; and the other two said they could not accept a maternity case at such a late date. For the last baby we went to the clinic in the hospital, but now they have a

rule that you can't get into the clinic or hospital without your own doctor, so I don't know what we're going to do. Perhaps I'll call a few more doctors, but I won't explain that my wife is so far along or that I am unemployed; maybe that way we can get someone to see her."

In reference to the question by the research social worker as to the family's use of the social, health, or welfare agencies that exist in this community, Mrs. A replied, "Three years ago when I tried to commit suicide I saw a social worker in a child and family agency, and I saw her two or three times after my last baby was born. But I really never cared for her because she insisted that my husband owned a business and would not believe that he didn't. My husband later went to that agency when I was in the hospital and tried to get a babysitter, but that didn't work out either. So I guess we've got to get along on our own somehow. These doctors and agencies don't seem to be available when you need them the most."

Commentary

A PUBLIC HEALTH NURSE

All of the professional workers who read this case must be distressed by the failure of every social agency to help the family. One would like to believe that it could not happen in one's own community. However, it is only too possible many places. Gaps in services, multiplicity of agencies, and lack of adequate staff make it ever more urgent to institute a system of interagency and interdisciplinary communication and make it work.

There were several obvious crises in the brief history given here when the representatives of the agencies which knew the family might well have thought of the need for continuing health supervision: the attempted suicide; the admission to the mental hospital; and the four pregnancies. Other people less directly concerned also knew something of this family's problems—the former employer, the six physicians who were called, the hospital clinic personnel, and the research social worker himself, who had interviewed the wife in the hospital. Though a public health nurse is not mentioned, it is probable that there had been opportunities for such a nurse to know this family, perhaps in a prenatal clinic or a well-child conference.

The total absence of a public health nurse is a glaring failure in this case. In most places, she is the common denominator among the health disciplines—the person nearest to the family and therefore a strong link in the chain of communication. She can share information with other agencies and give such nursing care and health guidance as are appropriate. Perhaps more important, she can be a helping person close to the family. In her "big sister" role [1] she may make a valuable contribution to the family's mental health. Because there are more public health nurses than other types of professional people (though not enough), and they often have a readier entree to homes, they provide a good channel for community health services and a practical means of supplementing skills in more limited supply. Even without an organized referral plan, the nurse's long-term contact with families makes it possible for her to direct them to the existing resources and bring their needs to the attention of others at times of stress.

It is evident, however, that the medical and social agencies which have been concerned with this family have not been able to provide the immediate followup and care indicated. Perhaps this means that everyone's responsibility is no one's.

Such acute situations as this will be repeated until health and social agencies make a plan for working together. A council of social agencies may be the nucleus for such a plan. But a wider referral system is needed, since patients are often admitted to institutions outside the local jurisdiction. In the case described, for example, a referral from the State mental hospital might have moved the family service agency to give assistance in arranging for day care or homemaker service which would have enabled the father to keep his job. If this was not possible, visits by a public health nurse might have given the grandmother enough help to care for the children at home.

The director of the local health department is one of the officials in a strategic position to start joint planning, or to give leadership in the reorganization of a plan that has broken down. This official agency does have a responsibility for community planning to meet the health needs of the population. It should be recognized that a referral system is only a first step. This should lead to an arrangement for conferring and problem solving.

In the present emergency, the research social worker will no doubt recognize the need for immediate obstetric care and report this to the local health department. Thus available sources of medical and hospital care can be brought to the patient. From

this point, a new beginning can be made in learning the family's needs and finding a way to meet them.

KATHARINE AKIN
Associate Director, Public Health Nursing Service, Georgia Department of Public Health

A MEDICAL EDUCATOR

When Mr. A inquired at the local agency about a "babysitter," the chain reaction terminating in the degeneration of the economy and morale of this family would have been avoided if a referral could have been made to an efficient homemaker service. Failure to mobilize this assistance could stem from either lack of a homemaker service in the community or lack of information on the part of the agency worker that such did exist. An up-to-date directory of available services is indispensable to good medical or social practice and should be consulted as readily as the telephone directory until the professional person involved develops a working knowledge of where to get the help which is indicated.

Mrs. A suffers from two medical problems: arrested emotional illness and present complications of pregnancy.

Whose responsibility to see that her problems receive attention? Before she was discharged from the mental hospital, the physician in charge of Mrs. A's care was responsible for knowing about the home situation to which she would return, and for referring her, through a paramedical assistant, to a local psychiatrist, mental health clinic, or "home care" program.

Whose responsibility? The research social worker could also have obtained the facts about the home situation and have triggered action in the home community to ameliorate the complicated family situation long in advance of Mrs. A's discharge from the mental hospital. A local agency (physician, mental health clinic, or family agency) should have been alerted to get an appropriate person into the home to care for the children so that Mr. A could stay on his job, and to prepare the home for Mrs. A's return so that she would find a situation which would aid rather than exacerbate her emotional illness. (From the timing of events, it is doubtful if the mental hospital medical personnel could have detected Mrs. A's pregnancy prior to her discharge.) Admission of Mrs. A to the local maternity clinic could then have been facilitated by the local physician or agency to whom Mrs. A should have been referred by the research social worker or by the responsible physician in the mental hospital.

The neglect and deterioration of the A family is a consequence of a breakdown in communication between professional people at every step in this long sad chain of events. Good medical and related social work practice is impossible if professional people do not share information and cooperatively set a course of action suited to the needs and requirements of the patient and family. That the family must act responsibly is also essential. Failure of such collaborative action leads to human wreckage of untold cost to the health and well-being of the patients, the family and the community.

What can and should now be done after all the damage has been created? A conference of very busy and overburdened professional people will have to be held in the local community to review the facts, organize resources of people, time, and money to develop and act in concert with Mr. and Mrs. A on an appropriate plan. This would require, at a minimum, three or four conference-hours of an obstetrician, a psychiatrist, a psychiatric social worker, a psychologist, a public health nurse, or visiting nurse from a voluntary organization, a worker from the local welfare department, and a worker from a local family agency. And then the plans made in these conferences must be carried out and followed up. An expensive course of action? Most certainly. But it is cheap compared with the long-term cost to all concerned in time, money, and suffering if the A family is allowed to drift further into deeper and deeper dependency.

J. GARTH JOHNSON, Ph. D.
Professor and chairman, Department of Community Health, Albany Medical College of Union University, Albany, N.Y.

A PUBLIC HEALTH PEDIATRICIAN

There are several medical problems which this case presents: maternity care for the mother; psychiatric care in view of the probability of recurrence of the mental disorder; and medical care and health supervision for the 2½-year-old child. In addition, planning needs to be undertaken promptly for care of the child and maintenance of the integrity of the household in the event of a recurrence of the mother's mental disorder. The father needs help to secure employment, and steps should be taken to assure family income maintenance.

An integrated, regionally or locally administered

health and welfare service, bringing medical, social, and psychiatric resources into action would be the most effective means of dealing with situations of this type. In the absence of such a service, a family service agency could well assume central responsibility, if one exists in the area. If not, the necessary minimum would be a joint consultation of the psychiatric hospital staff, the local welfare department, the local hospital, and local health department, with assignment and acceptance of responsibilities by each.

The mother's mental disorder in this case has existed for some years and was known both to a social agency and doubtless to a general or psychiatric hospital at least 3 years previously, when suicide was attempted. Services should have been begun then and continued. It appears that the social agency allowed the family to drop from sight and that no psychiatric care was provided following the attempted suicide—oversights difficult to justify in the light of the likelihood of further problems.

The case illustrates the need for both the social worker and physician who initially recognize the existence of a problem such as this to determine upon a definitive plan of action and to pursue the plan (revised as necessary) for an extended period of time.

WILLIAM M. SCHMIDT, M.D.
Head of the Department of Maternal and Child Health, Harvard School of Public Health

A PUBLIC WELFARE WORKER

As has been stated so clearly in "Multi-Problem Families—a New Name or a New Problem":[2] "It has become increasingly possible for families to 'fall through' the network of agency services with no single agency taking specific responsibility for 'seeing the family through' over a period of time." The point is well illustrated in this case. The A family needed the guidance and support of an agency which could provide, through its own programs or by referral to other agencies, the various services indicated—homemaker service, financial assistance, psychiatric treatment, medical care, employment counseling, and so on.

In the public welfare agencies we have long since learned that referrals need followup and that there must be "ready means for interagency collaboration on individual families."[2] But first, there must be agreement on which agency will follow through and retain responsibility for securing services as they are needed. We believe that the public welfare agency because of its basic and broad responsibilities will increasingly be the focal point in most communities to provide the needed social services and to arrange for essential services in other fields.

There is another aspect, too. Does the community provide the variety of services families may need? Too often community patterns do not change to meet new needs or to provide new tools.

The cost of providing needed services is sometimes another block. Whether tax funds or voluntary contributions or both are involved, it is often difficult to interpret need with sufficient authority to secure financial support locally. Demonstration projects continue to be one of the best methods of interpretation, and funds for these are now more available than they used to be, from both private sources, such as foundations, and public sources, such as increased child welfare services funds from the Children's Bureau. Funds are also available from the National Institute of Mental Health, Public Health Service.

To give an example of the value of demonstration programs: The North Carolina State Board of Public Welfare in 1947 used a small portion of its grant of Federal funds from the Children's Bureau to demonstrate the effectiveness of homemaker service for children. Ten years later funds from the Doris Duke Foundation were used to demonstrate the value of such a service in helping aged and disabled persons remain in their own homes. The demonstrations pointed up the values dramatically enough that "across the board" homemaker services are now being developed as ongoing programs in county departments of public welfare.

One last word, this about staff, at the risk of belaboring a point with which we are all too familiar. We must have in every corner of this country more and better trained staff if we are to see fewer families fall through the network of agency services. On the other hand, we will never have all the staff we need so let us not wait for that to happen before we move. Imagination, enthusiasm, and determination go a long way too.

MYRTLE WOLFF
Director, Division of Child Welfare, North Carolina State Board of Public Welfare

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[1] Caplan, Gerald: The mental hygiene role of the nurse in maternal and child care. Reprinted in *Concepts of mental health and consultation*. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 373. 1959.

[2] Social Research Services, State Charities Aid Association: Multiproblem families—a new name or a new problem. New York. 1960.

An essay review . . .

THE ORIGINS OF DELINQUENCY

CATHARINE V. RICHARDS
Youth Services Consultant, Welfare Council of Metropolitan Chicago

IN a recently published book, "Delinquency and Opportunity, a Theory of Delinquent Gangs,"[1] Richard A. Cloward and Lloyd E. Ohlin explore two basic questions baffling most observers of delinquent gangs:

1. Why do delinquent "norms" or rules of conduct develop?

2. What are the conditions which account for the distinctive elements of specific systems of delinquent norms?

In pursuing these questions they reach the conclusion that delinquency is, in the main, the product of the interaction of social systems—and that therefore social systems and their values are the most logical targets for preventive efforts.

Rigorously adhering to an analysis of precise propositions, stemming from the theoretical formulations of Durkheim[2] and Merton,[3] the authors take the reader through a critical examination of various theories of delinquency. By concisely limiting their definitions to fit their purpose, they develop a dynamic theory of delinquent gangs that can account for changes in the structure and behavior of gangs over a period of time.

The writers abstract from the omnibus of delinquency a manageable unit of deviant behavior and designate this as a "delinquent subculture." This subculture they define as ". . . one in which certain forms of delinquent activity are essential requirements for the performance of dominant roles supported by the subculture."

They then identify three subcultural differentiations that are prevalent among adolescent males in some lower class areas of urban communities. These subcultures constitute routes of adjustment to the environment and its prevalent values from which the adolescent gangs take their specific colorations. These are of three types descriptively labeled according to the central position or dominance accorded the delinquent activity: (1) *the criminal gang* in which the group goal is material gain through illegal means such as extortion, fraud, or theft; (2) *the conflict gang* in which violence is the focal interest and status is achieved through physical force or intimidation; (3) *the retreatist gang*, characterized by its dominant interest in the use of drugs.

The distinctive elements of these gangs evolve according to the interaction of the social structures of the community, specifically between those relatively stable systems which accommodate different age levels of people and bring together the carriers of conventional and of deviant values. For example, in some parts of Chicago the youth may see and describe a criminal model as the man with "clout (influence), women, and Cadillacs" who is not on the "slave" (indicating he doesn't earn his living by legitimate work). At an early age in such an area, the youth may begin to steal for a variety of reasons that are mostly sanctioned by the people in his neighborhood. Gradually his stealing brings him into contact with fences, bondsmen, law enforcement officials, politicians, fixers, and so on. Here are the intermediaries between the conventional values of the larger society and the deviant values of the subculture. There develops an interdependency between the subculture and these intermediaries in which each serves the other. This creates an environment nurturing delinquency.

The authors suggest that youth living in such environments are confronted with a major problem of adjustment because of the disparity between "what they are led to want and what is available to them." Where the youth have internalized conventional goals, where they have limited avenues to these goals

and are unable to revise their aspirations downward, "they experience intense frustration." To manage the frustration, the youth may explore the adaptive routes of criminal, conflict, or retreatist structures.

This theory of delinquency and opportunity is logically trim and neat. The writers deliberately exclude considerations that introduce complexity. For example, in Chicago the heaviest incidence of delinquency in a given area is 21 out of 100 male youth 12 to 16 years of age.[4] The question the theorists acknowledge but do not encompass is: Why is it only a small proportion of the population exposed to a relatively similar environment handle their frustrations by resorting to an "exploration of nonconformist alternatives"? The theory builders extricate themselves from this difficulty by making it vividly clear that they are focusing on delinquent norms rather than on delinquent acts.

Regardless of this shortcoming the book is singularly significant from the viewpoint of both theory and practice. The writers see delinquency as a product of the interaction of social systems. They conclude that the target for preventive action is not the individual or the group with the delinquent pattern, but the "social setting that gives rise to delinquency." It seems to follow that this may constitute an invitation to social change. Those who want to take action against delinquency will have to systematically study and bring about change in the principal structures of the community; namely, government, education, business and industry, recreation, family, and religion. Intervening strategically with the operation of systems, that are in themselves systems, in order to create a nurturing environment for human potentials is a complicated and difficult task requiring concerted and comprehensive action of many forces in the community. To the extent that this is achieved, children and youth will be provided with a social milieu favorable to their growth in a democratic society.

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[1] Cloward, Richard A.; Ohlin, Lloyd E.: Delinquency and opportunity, a theory of delinquent gangs. Free Press, Glencoe, Ill. 1960. $4. 220 pp.

[2] Durkheim, Emile: Suicide; a study of sociology. (Translated by J. A. Spaulding and George Simpson; edited by George Simpson.) Free Press, Glencoe, Ill., 1951.

[3] Merton, R. K.: Social theory and social structure. (Revised edition.) Free Press, Glencoe, Ill., 1957.

[4] McKay, Henry D.: Rates of delinquency in communities in Chicago 1953–57. Institute for Juvenile Research, Chicago, June 1959. (Mimeographed.)

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

MAN ENOUGH FOR THE JOB. 25 minutes; sound; color; purchase or loan.

Tells the story of how membership in a 4-H Club helps a city boy adjust to country life by instilling in him a sense of personal pride and responsibility.

Audience: Group workers interested in activities of young people between the ages of 10 and 21.

Produced by: Sam Orleans & Associates.

Distributed by: Sam Orleans & Associates, 211 West Cumberland Avenue, Knoxville 15, Tenn.

YEAR OF BIRTH. 27 minutes; sound; black and white; loan.

Describes a study of the conditions leading to brain damage in infants. The study is being made by the National Institute of Neurological Diseases and Blindness in collaboration with universities.

Audience: Students in fields concerned with maternity and infancy; general public.

Produced by: Norwood Studios.

Distributed by: Mrs. Ruth Dudley, Information Officer, National Institute of Neurological Diseases and Blindness, National Institutes of Health, Bethesda, Md.

MOTHER LOVE. 26 minutes; sound; black and white; rent or purchase.

Shows experiments with rhesus monkeys indicating that body contact is the single most important factor governing an infant's love for his mother, and that deep emotional disturbances, even death, can result from deprivation of such contact.

Audience: Profressional persons concerned with child development.

Produced by: CBS Television, New York.

Distributed by: Carousel Films, 1501 Broadway, New York 36, N.Y.

PLANNING CREATIVE PLAY EQUIPMENT FOR YOUNG CHILDREN—Part I: Outdoor. 10 minutes; sound; color; purchase.

Shows how parents in a community combined their talents and imagination to build a playground for 60 preschool children, making use of waste materials, planning centers of activities, and constructing safe and sturdy play equipment.

Audience: Community groups, parent associations, teachers, city planners, boards of settlement houses, and other agencies planning for young children.

Produced and distributed by: University of California, 405 Hilgard Avenue, Los Angeles 24, Calif.

BOOK NOTES

DELINQUENT AND NEUROTIC CHILDREN; a comparative study with 100 case histories. Ivy Bennett. Basic Books, New York. 1961. 532 pp. $10.

Probing the backgrounds of 100 boys and girls under treatment at child guidance clinics, the author found in the 3-year study she reports here, support for the theory that different patterns of personality structure and interrelations exist in families of delinquents and in those of "passive neurotics." Also confirmed, in her opinion, was the theory that primary influences shaping a child's development and behavior are to be sought in the very early years.

The book presents individual psychological profiles of the children, who ranged in age from 5 through 16 years.

Supplementing the histories are results of intelligence tests, extracts from treatment session reports, and followup reports on therapy. An appendix with 47 tables includes data on clusters of factors affecting delinquent children and the neurotic group, and their respective interests and achievements.

The author, who includes copious references to the literature on delinquency and neurosis of children, urges team collaboration combining "the outlook of dynamic psychology with the technical methods of modern research work."

BLIND CHILDREN in family and community. Marietta B. Spencer. Photographs by Frank Agar, Jr., and Carol Safer. University of Minnesota Press, Minneapolis. 1960. 142 pp. $4.25.

The ways in which child guidance principles can be used to start blind children on the road to healthy, useful, and meaningful lives are suggested chiefly through captioned photographs and through occasional textual commentary.

For the benefit of families and professional workers concerned with the training and welfare of the blind, the author, a medical-social worker, has selected views showing blind children of preschool ages in action—eating, playing, going to bed, dressing, and learning simple habits and skills. Her central theme is that these children have the same needs, problems, and potentialities as children who can see. Much depends, she maintains, on community attitudes towards the blind child's family and on how much these attitudes meet the family's social and emotional needs.

Publication of the book was financed by the Hamm Foundation and the American Foundation for the Blind.

ESSENTIALS OF FAMILY LIVING. Ruth M. Hoeflin, John Wiley & Sons, New York. 1960. 282 pp. $5.75

This book was written as a text for college students interested in preparing themselves for adult responsibility of family life. Through the discussion of growth and developmental ages and stages, an attempt is made to help the student to achieve a better understanding of self as a step toward achieving emotional maturity.

The developmental approach is used to interpret family composition, the family cycle and the interaction processes within the family. The book discusses the adult-centered versus the child-centered home, especially in relation to the impact of the advent of children into the family unit. Throughout the book, the theme of providing a feeling of love and security is interwoven with the child's need to operate within fairly well-defined limits.

The book provides case stories and other illustrative material and lists discussion questions and references at the close of each chapter.

While the book is directed to college class use, it could be used as resource material for public health nurses and others working with adolescents and their families.

JORDI. Theodore Isaac Rubin, M.D. The Macmillan Co., New York. 1960. 73 pp. $2.95.

The gaping hole of the garbage can, like an ear that can hear his thoughts, and the stubby, raining trees that come down to look for him and strangle him with their roots are part of the inner world of Jordi, the schizophrenic child in this story.

Written by a psychiatrist affiliated with the American Institute for Psychoanalysis and the Karen Horney Clinic, the tale follows the 8-year-old hero's escape and exploits in a New York subway, his voluntary return, and his steps to recovery in a special school. Like a theme in counterpoint, the parents' reactions and activities as well as test results are brought in periodically.

ANXIETY IN ELEMENTARY SCHOOL CHILDREN. Seymour B. Sarason, Kenneth S. Davidson, Frederick F. Lighthall, Richard R. Waite, and Britton K. Ruebush. John Wiley & Sons, New York. 1960. 351 pp. $7.75.

Focusing on anxiety about tests and test-like situations as a major cause of the gap between performance and potential of the elementary school child, the authors present results of 6 years of research, supported by the National Institute of Mental Health, Public Health Service, on anxiety among school children in three Connecticut communities. All of the authors are associated with Yale University. Stressing the test-giving and test-conscious character of our culture, they suggest that clarifying the test factor in anxiety will illuminate knowledge of anxiety in general.

The authors see relationships between anxiety over tests and attitudes about self, unconscious significances, parent-child relationships, and other anxieties, and regard test anxiety as a danger signal.

Using test-anxiety and general anxiety scales in studying the children, they found that the child who is highly anxious about tests is more sensitive than other children to the way adults seem to regard him—for instance it makes a difference to him in what order the teacher calls upon him. They also found that test-anxious children had been exposed to more unfavorable experiences than the other group, and their distribution showed little relation of such anxiety to class.

Interviews with parents showed that fathers were more aware of the children's degree of anxiety than the mothers, particularly those mothers of highly anxious children.

HERE AND THERE

International Conference of Social Work

The 10th International Conference of Social Work, held in Rome, Italy, January 8–14, 1961, was larger than any of its predecessors. The registration was over 2,400 with 51 countries represented, although only 28 countries have national committees representing the conference.

Theme of the conference was: "Social Work in a Changing World: Its Functions and Responsibilities." As with the previous conferences, the program was organized with plenary sessions in the morning and with meetings of the 6 commissions and 16 study groups in the afternoon. Because of the large attendance, special afternoon meetings were held for those who could not be accommodated in the commissions or study groups.

At the first plenary session, the chairman of the Italian committee set the tone of the conference. Pointing to the fundamental tenets of social work—the importance of human dignity and the rights of the individual—he said that social workers must help lead man to knowledge of his own dignity and the dignity of community life. Opening up new vistas for social work, he added: "We can no longer speak of old worlds and new worlds. All countries are evidencing marvelous energies of renewal."

George Davidson of Canada, the president of the conference, threw out direct challenges to complacency by asking the conferees the question: "Is social work changing with the changing times?"

One sensed early that the concerns and emphasis expressed in this conference differed from those of previous conferences. Gone was the concentration on problems of mass poverty and want, and on the methods of dealing with these problems. And, significantly, the cold war did not raise its ugly head. Instead, there was the constant reminder that we are living in an ever-changing world, the needs of which are constantly evolving, and that social work must gear itself to these changes in order to make its unique contribution.

This theme of "change" was reiterated throughout the conference. It was pointed out that while change is rapidly taking place in every country, the pace of change varies from country to country. We were told that where change is most rapid, most can be learned; that therefore social workers have much to learn from the so-called "developing countries." Thus, change was viewed as something to be welcomed.

But while change was viewed as a stimulating challenge, many concerns were expressed in relation to it. Much was said about the problems which come with industrialization and urbanization. It was pointed out that as an increasing part of the population of a country concentrates in large towns, deep social and cultural changes occur. Man is deprived of cultural values and finds nothing to take their place. He relies less and less on his family. The family no longer assumes the responsibility it once had for both the physical and emotional support of its members. While social security helps to give man a sense of security, it tends to make him feel "like only a number."

Industrialization brings a higher standard of living, but it may bring a greater gamble to families and individuals, one speaker said. The destitution that some people experience as a result of industrialization tends to be greater than that experienced by people who live on the land. Man becomes increasingly alone in his environment as the cohesiveness of his family group weakens. New kinds of skills and adjustments are required of him.

It was also pointed out that in countries that are industrializing amid political upheaval, social workers are trying to accomplish in a decade that which has taken place over long periods of time in other countries. But there was a strong consensus that social work must give more recognition to the problems individuals have to face in a highly industrialized society.

Great concern was expressed in relation to the huge new forces which have been released by man in recent decades. This posed the unanswered question: Will these forces be used for the welfare of man, or will they be used for the destruction of man himself?

Social Work's Importance

Recognition of the importance of social work in the world today focused attention on the broadening scope of social work, a scope expected to continue to expand in the years ahead. Social work was described as a dynamic activity, shaped by the social, economic, and cultural conditions of the various countries in which it is carried out. These dynamic aspects and the effects of change were seen as reflected everywhere.

In the postwar period, social work had to face problems of reconstruction, of saving and reshaping lives. It had to start with the stern necessity of feeding the hungry, reuniting families, resettling the displaced. This was a time when social work policy grew out of negative attitudes and a variety of fears. Now, at Rome, social workers from everywhere showed that they felt this to be no longer necessary, that now is the time to work for a constructive world.

One speaker advocated more active participation of the users of social work in the social work process, saying that this will prevent the dehumanization of social work. We can only have successful community development, he said, if the users are aware of their needs and can take part in the efforts to meet them. Recognizing that this demands the preparation of the users, he pointed out that this preparation was an important task for social workers.

The conferees showed grave alertness to the fact that today's evolving society is bringing increasing problems of relationships "between man and the world and between man and other men" because, as one speaker put it, "existence in the world is now one of coexistence." They saw social work as having an important role in establishing significant relationships between man and his institutions. They stressed the need for teamwork and coordination of services. In the past, one-dimensional approaches were the order of the day. Today's challenge, as expressed at Rome, is to fit each of these

dimensions into social work's wider role.

Definitions

Dr. J. F. de Jongh, director of the *Amsterdamse Sociale Academie*, in differentiating between "social welfare activities" and "social work," used the term "social welfare activities" to cover the broad range of efforts directed toward improving the quality of social life. He reserved the term "social work" for specific activities requiring certain kinds of competence. Social welfare, he said, represents the activities of many people to improve the welfare of individuals and communities. It takes different forms: services to individuals; social action; and community planning. It involves values, philosophy, and social resources.

Social work, he asserted, is emerging gradually from the social welfare field. It calls for special competence to diagnose and understand human activity and problems and how to deal with them. He traced its beginnings to the time when social welfare workers began to see phenomena around specific problems—alcoholism, juvenile delinquency, family breakdown—and began to develop skills in dealing with individual cases of such problems in a more scientific way. This type of work, he maintained, is still the core of social work; although social work has moved on to achieve a greater understanding of the surroundings of clients, which has led to an interest in community planning.

Dr. de Jongh further distinguished the two fields by stating that social work is an activity carried out by trained specialists, while social welfare is a citizen's concern. In the social welfare field, leadership should belong to the community as well as the choice and direction of activities, he maintained. Volunteers are the community's agents, he pointed out. Social work, on the other hand, since it requires a special competence, must be an activity of trained professionals, he insisted.

Social workers have a function in the social welfare field, said Dr. de Jongh, but a limited one, leaving plenty of room for others, especially other helping professions many of which are reaching out into this new field of human adjustment and human relations.

At the close of the conference one had the feeling that social work has achieved a significant and growing place of importance in our society today, and will be needed more and more in the future. We were told that the world must be committed to the defense of human values and while the history of mankind has been a chain of tears and miseries, it has also been one of hope and aspirations. As Nathan Cohen, dean of the School of Applied Social Sciences, Western Reserve University, said at the conference. "Social work has the conviction that man can be the master of his fate and, with his collective strength, can build a better world."

Mildred M. Arnold

Youth Fitness

The key to promoting physical vigor among the Nation's youth rests with the individual family rather than with the Government, said President Kennedy, addressing the Conference on Physical Fitness of Youth, held in Washington, D.C., on February 21, 1961. Summoned by the President to help chart guidelines for official action toward fitness goals, the 165 conferees represented chiefly physical education, sports, health, and youth groups, and appropriate Federal agencies. They were also addressed by Attorney General Robert F. Kennedy and Secretary of Health, Education, and Welfare Abraham A. Ribicoff, who emphasized the need, in the exacting years ahead, for "people who can work hard and think fast."

Six work group discussions stressed the role of good health in the full use of intellectual powers. The participants underscored the need for substantially revising health and fitness related activities of school systems and community agencies, and urged communities to organize demonstration programs testing new ways of meeting the health and recreational needs of youth.

Among conference recommendations for Federal action were:

- Expanding the National Defense Education Act to support further development of high-quality programs of school health, physical education, and recreation.
- Promoting the use of school facilities for after-school and weekend play.
- Seeking ways to foster among children those leisure activities with high carryover value.
- Stressing physical education programs in the Nation's elementary schools.
- Setting up a task force to review the relationship of the President's Council on Youth Fitness with the activities of 34 Federal agencies serving youth and children.
- Expanding the Council's staff and setting up field representation in each of the nine regions of the Department of Health, Education, and Welfare.

For Youth

On March 1, 1961, President Kennedy signed an executive order creating the Peace Corps, an agency that will send out volunteers to build, teach, and work in newly developing countries. Financed by the President's contingency funds, the activities of these "doers and workers" are planned to dovetail with the advisory and consulting functions of other official missions abroad. Fields of action for the volunteers, as mapped out in the basic "working hypotheses" prepared by R. Sargent Shriver, the Corps Director, include education, health, agriculture, and large-scale construction and industrial projects. Assistance in the form of money and manpower may be channeled to private projects, if certain criteria are met.

Plans call for national recruiting of persons over 18 years of age who possess technical ability needed in specific projects, physical stamina, and emotional stability.

Initial sifting is accomplished through a four-page questionnaire, which was distributed for the first time in late March by a skeleton force of the 75 staff members recruited up till then. The first recipients were the 20,000 persons from whom inquiries have been received—the majority of them college students, but also including physicians and other professional people. Batches of questionnaires also went to 2,000 colleges and Agricultural Extension Services, and some 4,000 post offices. The questionnaire consists of short-answer questions on type and degree of technical skills, education, work and hobby experience, language ability, and knowledge of selected foreign cultures.

Applicants will be tentatively chosen after interviews and further examinations held at 54 places throughout the Nation and outlying regions, and then trained for 3 to 6 months. The

usual length of service will be 2 years, during which the volunteers will be paid subsistence allowances only; payment of $75 per month of service will be made on completion of their terms. Service in the Corps will defer but not exempt the volunteer from service in the Armed Forces. During both service and training, Corps members are subject to separation if they cannot meet the new challenges.

The Corps plans to have several hundred volunteers in the field by the end of 1961.

. . .

Under discussion at the Interdepartmental Committee on Children and Youth, is a proposed nationwide work and service program for youth presented to the committee at its December 1960 meeting by its Subcommittee on Transition from School to Work. The Interdepartmental Committee is a coordinating body of 34 Federal agencies serving children.

The program would have the following features:

- The Federal Government, States, and local communities, with Federal financing, would employ youths of 16 to 21 years of age full time on projects sponsored by voluntary nonprofit groups and public agencies.
- The projects would involve service in hospitals, day-care centers for children, museums, parks and forests, programs for the aging, libraries, citizenship and literacy programs—operating at the community, county, State, or Federal levels, or internationally through voluntary agencies, the State Department, or the United Nations.
- Initial distribution of funds would follow a formula based on the ratio of the population between 16 and 21 in the State and local community to the nationwide population in this age group. Ten percent of the funds available would be withheld at the Federal level for national and international projects.
- Participation would be voluntary with universal eligibility for all within the age group, except that those under 18 would be required to have the consent of their parents or guardian. It would be open to 100,000 young people the first year, 200,000 the second, and 300,000 the third and thereafter.

. . .

The Youth Studies Center, University of Southern California, is using Santa Monica as a demonstration community for three types of studies involving the participation of lay and professional leaders, personnel serving youth, and hundreds of adolescents. The studies include a social profile of the community, with an accent on the youth; the critical factors in transition from youth to maturity, in longitudinal perspective; and authority relationships of the individual adolescent.

Projects for the Retarded

Forty-nine States and 3 other U.S. jurisdictions are now emphasizing special programs or related activities concerned with mental retardation as part of their maternal and child health programs.

None of these programs existed before 1954, the year the Children's Bureau first granted funds through its health services programs for the development of four demonstration diagnostic clinics—in California, Hawaii, Washington, and the District of Columbia. The inclusion of $1 million of funds earmarked for services to the mentally retarded in the congressional appropriation to the Bureau in 1957 and in subsequent years has resulted in the rapid multiplication of these maternal and child health projects. Many of the States have been adding their own funds to expand the projects and make them a regular part of the State programs.

As the score now stands in the maternal and child health programs:

- 52 States and jurisdictions have planned some special service for mentally retarded children.
- 46 States are offering clinical services to retarded children.
- 14 medical schools are using the clinical services to train medical students, residents, and interns.
- 50 of the Nation's 82 special clinics for retarded children have been developed through this program.
- 10,000 retarded children mostly under age 9 and their parents are annually served by these projects.
- 26 States have developed programs for the detection and treatment of phenylketonuria.
- 25 infants with phenylketonuria have been located and placed under treatment (and mental retardation prevented) in 1960.

Many of these programs include study aspects, such as the dental problems of the retarded, retardation among Indian children, and the needs of children on waiting lists of State institutions.

Children of Migrants

Over 500,000 domestic agricultural migrants and their families—including between 350,000 to 450,000 children under 18—are "trapped in a vicious circle of unending poverty and rootlessness," according to a report prepared by the Children's Bureau. This report was prepared at the request of the Senate Appropriations Committee of the 86th Congress and submitted by the Secretary of Health, Education, and Welfare in January 1961. Facts are presented on the families in the country's five major agricultural migrant streams, gathered from a wide spectrum of sources, ranging from Federal, State, local, and voluntary agencies to congressional and executive committees. Among its highlights are:

- Migrant farm workers represent the lowest economic level of any major group in this country, with average earnings of $859 annually; and, along with their children, the lowest educational attainment.
- In the entire Nation there are 24 State-licensed day-care centers primarily servicing domestic migrant children, with a combined capacity of fewer than 1,000 children. Thirteen of these centers are in one State, New York.
- About 42 percent of the 813 counties in the United States affected by family migration have no full-time, public child-welfare services. Of 39 counties estimated to have 5,000 or more migrant workers, 10 have no available service from a full-time, public child-welfare worker.
- Migrant families have higher infant and maternal mortality rates, and

more diarrheal diseases, nutritional deficiency, and communicable diseases than the rest of the population. A large proportion of pregnant women in migrant families receive no prenatal care.

• The migrants' access to existing health and welfare services is hindered by cultural differences, language barriers, lack of education, mobility or nonresident status, long distances to clinics, and shortages of health and welfare workers.

The report reviews the origin of agricultural migration in this country, the composition of the migrant population, and the history of Federal, State, and voluntary efforts to better the conditions of these workers.

In conclusion, the Children's Bureau recommends the following steps for immediate action:

• Expanding child-welfare and maternal and child health services for migrant families, by increasing current services and developing and demonstrating new adaptations, especially of day-care, well-baby, and other outpatient services.

• Providing more advisory assistance and guide material to agencies and organizations helping migrant children.

• Giving more encouragement and assistance to research and demonstration efforts toward developing new or improved measures for aiding these children, in the fields of child welfare and health.

• Increasing, investigating, reporting activities related to the development of effective measures for improving the health and welfare of migrant children.

• Informing the public of findings derived from these activities through a nationwide campaign.

The report, entitled "Children in Migrant Families," may be obtained from the Senate Appropriations Committee, The Capitol, Washington 25, D.C.

Poison Control

The American Association of Poison Control Centers recently adopted tentative standards for centers to promote round-the-clock service, the maintenance of up-to-date data on poisonous substances and treatment, and the broadest possible dissemination of this information.

The National Clearing House for Poison Control Centers lists 421 centers, of which 377 provide treatment as well as information service, located in all but two States and every territory. The outgrowth of a poison control program begun in 1953 by the Illinois Chapter of the American Academy of Pediatrics, the first poison control center was established in November of that year in Chicago. (See "A New Life Saving Device is Launched," by Dr. Edward Press in CHILDREN, May–June 1954.)

Differentiating between information centers, which give poison information without providing treatment, and poison control centers with both information and treatment facilities, the association includes among other recommendations:

• *For information centers:* Listing the sources and the availability of antidotes; keeping records of requests for information, including name, age, address of suspected case; and type and amount of substance ingested.

• *For the poison control center:* Appointing a physician as the center's director and an alternate to serve in his absence; orienting emergency staff in treatment techniques.

• *For both types of centers:* Setting up 24-hour operations; encouraging preventive education programs in the community.

Cuban Refugees

An emergency welfare program to meet the minimum needs of Cuban refugee families and children in southern Florida, begun in November 1960 on order of former President Eisenhower, has been broadened in recent months to include Federal provision of funds for subsistence and other purposes. The action was based on recommendations of Secretary of Health, Education, and Welfare Abraham A. Ribicoff, following an on-the-spot survey of the conditions of refugees in Dade County (Miami) made in February 1961 at the request of President Kennedy.

The increasing influx of refugees from Cuba into the Miami area had led President Eisenhower to allocate $1 million for their aid out of the contingency fund of the mutual security program, to be spent under the direction of Tracy S. Voorhees, his personal representative. This assistance was channeled chiefly into defraying the costs of resettlement and of maintaining a refugee center in Miami as the hub of efforts by voluntary and State and local public agencies to provide the refugees with care, shelter, employment, and resettlement.

Producing $4 million more from the contingency funds, President Kennedy has authorized Secretary Ribicoff to develop activities to meet the minimum needs of the refugees for daily subsistence, resettlement, employment, education, and health, and for the care and protection of unaccompanied children. The Commissioner of Social Security has been delegated the responsibility of administering all phases of the program through the constituent agencies of the Department. He also acts as Secretary Ribicoff's representative with other Federal agencies involved in the program.

By April 7, more than 4,000 family and single cases received aid administered through the Florida State Department of Public Welfare with the help of Federal funds. About $352,000 of public assistance funds had been distributed to the recipients, with the payments averaging $70–$85 per month.

Through contracts with voluntary and public agencies, the State agency acts for the Federal Government in providing foster care for a considerable number of unaccompanied children.

Through an arrangement with the Florida Department of Education, the costs of providing grammar and high school education to approximately 3,500 Cuban children in the Miami area are partially paid out of Federal funds. Besides waiving school fees required of nonresidents, for a number of the needy children, Dade County school authorities are furnishing hot lunches for some of the Cuban children.

Other costs partially borne by the Federal Government are those connected with construction of temporary classrooms and the provision of adult education classes, including English-language courses, orientation to the United States, and vocational training.

On March 20, President Kennedy approved a $75,000 grant to the University of Miami to assist Cuban scholars and professional leaders in educational pursuits.

Federal loans have been made to 323 Cuban college students through 15 institutions of higher learning in the United States. The students may borrow up to $500, without interest, payable within 5 years.

Federal money also continues to underpin the resettlement work carried

out cooperatively by voluntary agencies—principally the Catholic Relief Committee, Church World Service, the United Hebrew Immigrant Aid Society, and the International Rescue Committee—through payment of transportation costs and expenses associated with adjusting in the new locations. These agencies have resettled more than 1,600 Cubans from Miami throughout the country.

Also cooperating in this phase of the program are the Immigration and Naturalization Service, which has facilitated the process by which displaced Cubans accept employment; and the U.S. Employment Agency, which helps them find work. The University of Miami maintains a roster of displaced professional persons for retraining and placement.

For essential health services—including immunizations and chest X-rays for tuberculosis detection—the refugee center maintains a clinic jointly set up in 1960 by the Dade County Health Department and U.S. Public Health Service. The latter agency provides a physician who directs the work with the assistance of Cuban physicians.

By mid-April some 10,000 cases were registered at the refugee center for service under the program.

Child Welfare

Representatives from the attorney generals' offices and child welfare directors of eight States and members of the Children's Bureau staff met in San Francisco for 2 days late in February in a biregional conference on adoption laws and procedures sponsored by the Children's Bureau, for the States in regions VIII and IX. The conference was concerned with identifying the types of laws needed in regard to the termination of parental rights and the protection of children in adoptive placements; workable procedures in providing services to unmarried mothers; and ways of improving interprofessional relationships. A springboard for part of the discussion was a draft of a document being prepared by the Children's Bureau to serve as a guide for State legislation on adoption. The States represented at the conference included Arizona, California, Colorado, Hawaii, Nevada, Oregon, Utah, and Washington.

Inservice Training

A new residential center for inservice training in neighborhood social work was opened in Chicago during the fall of 1960 by the National Federation of Settlements and Neighborhood Centers. Financed during the first 3 years by a Field Foundation grant, the center occupies a wing of the Hull House, founded in 1889 by Jane Addams.

The center provides concentrated 1-week courses in specific phases of neighborhood work to settlement or neighborhood house executives, board members, experienced workers, and newcomers to the field. They focus on such subjects as: services to specific groups—ethnic minorities, hard-to-reach youth, multiproblem families, mobile populations; administration; planning and carrying out research projects; and orientation to settlement work. Classes are limited to 25 students.

Guides and Reports

ADC: PROBLEM AND PROMISE. Kathryn D. Goodwin, Peter Kasius, Kermit T. Wiltse, and Justine Fixel. American Public Welfare Association, 1313 East 60th Street, Chicago 37. 1960. 40 pp. $1.

One of a series supported by a special grant from the Rockefeller Brothers Fund, to help public welfare agencies carry out the provisions of the Social Security Act, this pamphlet contains three papers which assess the aid to dependent children program in relation to its purpose, the criticisms against it, administrative responsibilities, and future possibilities.

THE FURIOUS CHILDREN AND THE LIBRARY; by members of the staff conducting the research project at the National Institute of Mental Health and the librarian of the Patients' Library, National Institutes of Health, Bethesda, Md. *Top of the News*, 50 East Huron Street, Chicago 11, Ill. 1960. 19 pp. Minimum order, 3 copies for $1.

Presents reactions of the authors to the value of the library in the treatment of six extremely aggressive, emotionally disturbed children. Reprinted from *Top of the News* of March, May, and October 1960.

THE COURT AND PROTECTIVE SERVICES; their respective roles. Vincent De Francis. Children's Division, American Humane Association, 896 Pennsylvania Street, Denver 3, Colo. 1960. 19 pp. 15 cents. Quantity discounts on request.

This paper, published in pamphlet form, discusses the purpose and functions of two agencies—the juvenile court and child protective services—in relation to their separate and cooperative roles in the process of achieving maximum results on behalf of neglected children.

LET'S TALK WITH ADOPTIVE PARENTS: a supplement to "All About You," an adoptive child's memory book by Marion A. MacLeod. (Listed in July–August 1960 issue of CHILDREN.) C. R. Gibson and Co., Norwalk, Conn. 1959. 24 pp. Free on request from publisher.

For adoptive parents, gives some of the "why's" and "how's" of telling the adoption story to their children, in addition to suggestions for using the memory book.

WHEN A PARENT IS MENTALLY ILL; what to say to your child. Helene S. Arnstein. Child Study Association of America, 9 East 89th Street, New York 28. 1960. 47 pp. 50 cents. Quantity rates available upon request.

A guide for the parent who faces the problems that affect family life when the other parent is mentally ill.

IN THE JOURNALS

The Status of the Midwife

According to a study of midwifery as it survives in the nonwhite, rural communities of the Southeast, among formally trained and licensed midwives, the "granny" practitioners (those who are learned in the old folkway tradition) enjoy greater prestige and therefore larger practices than others. Reporting in *The American Journal of Sociology* of March 1961, the investigators find the keys to this difference in the status that comes with age and experience. ("The 'Granny' Midwife: Changing Roles and Functions of a Folk Practitioner," by Beatrice Mongeau, Harvey L. Smith, and Ann C. Maney.)

Human and Cow's Milk

Emphasizing that there is still no perfect substitute for human milk, Harold H. Williams of Cornell University's Department of Biochemistry compares its composition with that of cow's milk, in the *Journal of the American Medical Association* of January 14, 1961. ("Differences Between Cow's and Human Milk.")

He writes that human milk contains amounts of water, solids, and fats, similar to cow's milk, but only one-third of the protein and ash. Over 60 percent of the fat in cow's milk is composed of saturated fatty acids, whereas in human milk they make up less than 50 percent of the total fat content. He also points out that human milk fat has more than three and one-half times as much of the "essential" fatty acids as does the fat in cow's milk. Also, human milk has more vitamin A and less vitamins D and K.

There is nearly 10 times as much vitamin E in human milk as in cow's milk, and more linoleic acid, the author reports. The correlation of the higher content of linoleic acid with that of vitamin E is of more than passing interest, he adds. Recent studies show that increased ingestion of linoleic acid raises its content in erythrocytes and in brain tissue. Such changes, the author conjectures, are probably related causally to the vitamin E requirement. He points out that some of the striking differences in the patterns of minerals, fatty acids, vitamins, and several amino acids may be significant in the utilization of milk from one animal species by another.

Safety for the Handicapped

Rather than keep exceptional children away from environments believed hazardous, help them acquire habits that eliminate causes of most accidents associated with the handicapped, advises Ernest P. Willenberg, in the February issue of *Education* ("Safety Education for Exceptional Children"). The author, who directs the special education activities in Los Angeles city schools, suggests that school program planners use an ecological approach to the problem. Factors he mentions as likely to need attention in the child include his general mobility, use of visual or auditory perception, level of knowledge, kind of attitudes, quality of judgment, and use of skills. He also recommends strengthening resources for the child in the environment to compensate for hazards imposed by the handicap.

The series, a project of the National Safety Council and the Council for Exceptional Children, is also appearing in the periodical, *Exceptional Children*.

The Child's Potential

Aldous Huxley, writing in the *Bulletin of the Menninger Clinic* of March 1961, takes today's educators to task for failing to pass on to children what we have learned in the 20th century about the nature, limitations, and—through its "misuse"—the persuasive power, of language. ("Human Potentialities.") He wonders whether experimental training in semantics begun in childhood could bring out potentialities that would otherwise lie "buried under unexamined preconceptions and traditional notions or smothered by uncritically accepted propaganda."

Words used skillfully can arouse zeal, which, especially if aggressive, has the effect of a psychosomatic "pick-me-up" says the British author. Quoting William Blake, "Damn braces, Bless relaxes," Huxley asks how we can make the life of reason and kindliness "as thrilling as the life of crusading unreason."

Education, in his judgment, also fails to take into account the degree of variability in the human race, which is greater, he believes than in other species. He finds it absurd to herd creatures dissimilar temperamentally and in general ability and special gifts into one classroom for the same kind of intellectual, emotional, and ethical training.

Conceding that there is no other course at present, he foresees the day when we will think in terms, not of brute quantity, but of quality, when we will recognize, respect, and make the most of the enormous spread of human diversity.

Residence as a Privilege

How an open institution for disturbed adolescents who are mostly borderline delinquents manages to keep these young people in residence—and out of the training school—is outlined by Harry Finkelstein in *Social Casework* for March 1961. ("Containment of Acting-Out Adolescents in an Open Institution.")

In the Children's Home of Baltimore, of which the author is executive director, treatment of 30 boys and girls revolves around the philosophy that residence there is a privilege—the violation of which can mean commitment to a training school—rather than a period of compulsory confinement. About one-third of the group, with histories of stealing, firesetting, and sexual promiscuity, came from a training school; the rest because of behavior difficulties were removed from their own or foster homes.

Describing how the home has been transformed since 1957 from a custodial institution to a treatment center, the author emphasizes that its setting—a middle-class, residential neighborhood, whose public schools, churches, and recreational facilities these adolescents use—and the nearby bus stop—necessitate limiting admission to those who want to stay. This desire to remain, he points out, can be the fulcrum of power in helping the child build up inner controls or otherwise to curb antisocial behavior, and he draws on a number of case histories to illustrate the point.

READERS' EXCHANGE

LEMKAU: *Difficulties with parents*

Dr. Lemkau clearly points out that compassion dictates "the maximal use of normal channels of input" for stimulating the handicapped child. ["The Influence of Handicapping Conditions on Child Development," by Paul V. Lemkau, CHILDREN, March–April 1961.] Unfortunately, it is often the parents' misunderstanding and use of compassion which serves as a barrier to children being offered the stimuli which they need. One of the outstanding problems of the handicapped child lies in the parent who feels that the child is unable to perform and who therefore continues to carry out activities for him at an age when he should be learning for himself. Such an attitude of overprotection growing out of the concern that the parent has for the child, as well as a feeling of not having provided well for the child initially, leads to the type of deprivation of which Dr. Lemkau speaks.

Experience shows that it is not easy to convince such parents that they are in any way depriving their child. The question to the clinician is nearly always, "What more can I do?" The suggestion that they do less in the way of assisting and more in the way of offering to the child self-stimulating activities is often difficult for them to understand.

Dr. Lemkau demonstrates that true compassion for a handicapped child is best expressed by providing him with challenges, even hazards. To convince parents that this is the proper thing to do becomes increasingly difficult the longer they are accustomed to helping the child with the daily activities of life.

In an ordinary child the lack of a learning experience at the time when the child is ready for it leads to a deficit which can impair development. As Dr. Lemkau points out, the same kind of deficit may occur in the handicapped child if the stimuli which would provide the opportunity to learn are missing. The parents have an outstanding role in the provision of these stimuli. It becomes therefore an important clinical task not only to make the parents aware of the opportunity to provide such stimuli but to relieve them of the feeling that they are not doing all that they can to assist the child when they must force him into a necessary activity in what may seem to them a rather incompassionate way.

Henry H. Work
Department of Psychiatry, School of Medicine, University of California Medical Center, Los Angeles

Stimulation in nursery schools

One cannot read Dr. Paul Lemkau's penetrating article without increased compassion and insight regarding the effect of handicaps upon a child's development. His clarity in presenting concentrated scientific data makes a fresh and stimulating impact. While it is true that "knowledge and informed theory can keep compassion working at maximal efficiency," conversely, fuller understanding of the deprivations, complexities, and frustrations of handicapped children increases one's compassion and desire to help.

Particularly arresting is the thought that just as an eye deprived of light reacts by becoming useless, so may the whole child respond to lack of wide-range stimulation by becoming inert. Where there is decreased sight or hearing, not only is the individual deprived of basic experiences but the integrative function of the brain, which adds meaning to experience, is also understimulated.

Recognition of the need for adequate stimulation has helped counteract the earlier tendency to overprotect and hence limit unduly the experience of children with handicaps. Realization also that optimal opportunity for stimulation is essential in the early years has also led to the development of play groups and nursery schools for children with similar handicaps in vision, hearing, or movement.

Even more salutary may be the practice, which has been found highly valuable in some cases, of including a blind or deaf or palsied child in a nursery school for normal children. This plan has been less successful for children with mental or emotional handicaps.

Weekly observation classes for parents of retarded children, where each parent watches her preschool child interact with a group guided by a trained teacher, have been very successful, however, and have led to the formation of cooperative nursery centers for these children.

It is found in these groups that mentally handicapped children also gain from the stimulation of seeing other children and of using richer play equipment than many homes provide. Such guided observation and cooperative nursery groups have the added values of helping parents gain needed insights and skills for carrying on wisely at home and of providing emotional support from the other parents facing the same problem.

Katharine Whiteside Taylor
Supervisor of Parent Education, Baltimore Public Schools

PEAY: *What is cardiac neurosis?*

In commenting on my article, "The Emotional Problems of Children Facing Heart Surgery," in the November–December 1960 issue of CHILDREN, Marilynn Willmer was certainly right in stating that there is a lack of and great need for research in the aren of emotional problems of children with congenital heart disease. [CHILDREN, March–April 1961, page 80.]

Her comments about the continued cardiac neurosis in children in early adolescence seen at the medical center at the University of California at Los Angeles made me think a little more specifically about my own brief reference to the little "cardiac neurosis" we see in postsurgical children. Realizing that we both italicized the words, I began to wonder if we were both reacting to a similar definition of the words "cardiac neurosis" or if we perhaps each had our own understanding of this term.

I know of few, if any, studies in this area, but to pursue research here would certainly necessitate at least a working definition of what is meant by cardiac neurosis in children. How and when do we determine whether cardiac neurosis follows successful surgery, when

there are so many presurgical contributing factors to the children's behavior and attitudes? Such factors include the length of the illness, the type of congenital defect (Tetralogy of Fallot or Patent Ductus Arteriosus), the symptomatology, the life-threatening aspects of the condition, the degree of limitation on the child's activities, the parental care required, and so on.

I am glad Miss Willner commented on this particular point in my article because it made me take another look at my use of the term "cardiac neurosis." What *do* we mean when we say there is or is not cardiac neurosis following surgery?

Roberta Peay
Clinical Social Workers, National Institutes of Health

THOMAS: *No sacrifice of asepsis*

After reading Miss Thomas' article "Conflicts in Protecting the Newborn in Hospitals" [CHILDREN, May-June 1961], as a nurse who works in a hospital nursery I find myself asking the following questions:

- Is it necessary to sacrifice either the aseptic aspect or the psychological aspect of care?
- What has happened to the principles of aseptic techniques which we learned as students, and which proved effective before the advent of antibiotics?
- Has the nurse lost all the qualities which enabled her to give psychological support to the patient and her family?

I believe that no chance for spreading infection should be taken by permitting even one father into an area so important to the welfare of mother and infant as the delivery area, nor should groups be permitted to tour the delivery area. We do know that the more traffic in and out of an area, the greater chances are for contamination. Visitors to the obstetric division should be restricted for the same reason. However, whenever such restrictions are placed on families, mothers should be informed of the reasons for this early in the prepartal period.

Having a baby is probably no more traumatic than undergoing an operation. Do we invite husband, father, or mother into the operating room during an operation or into the recovery rooms following it? Do we invite prospective patients to tour the operating rooms? Asepsis is just as important in the delivery rooms as in the operating room, and psychological support is just as important to the patient undergoing surgery as to the mother having a baby.

"Rooming-in" would probably reduce chances for spreading infections, if true and complete rooming-in were practiced. However, I question the effectiveness of such halfway practices as permitting the infant to be with the mother and father during the day and then returning all infants to a central nursery at night. Such a practice would only increase the chance for spread of infection.

Because of the beneficial effects to both mother and baby, breast feeding should not be discouraged. Where cleanliness and aseptic principles are carried out both in the nursery and in the mothers' units, there would seem to be little danger in this.

Many questions need answering before definite statements can be made about advisability of wholesale early discharge. They include:

- Where do the organisms come from?
- What factors exist in those hospitals which report infections that are conducive to infection?
- Why do these conditions exist and what can be done about them?
- Why can't the person who takes care of the mother's children while she is in the hospital continue to help her care for them at home if she is discharged early?
- How available is public health followup to mothers discharged early?

Cleanliness is of prime importance in combating the spread of infections and must not be sacrificed under any condition.

Simple and adequate procedures for providing both aseptic and psychological aspects of care require understanding and cooperation by all persons involved in the care of mother and infant.

Mary M. McNeer
Supervisor of Nurseries, District of Columbia General Hospital

PAGE: *More of same needed*

I have just read Miriam Page's article, "Cohesion, Dignity, and Hope for Multiproblem Families," [CHILDREN, March–April 1961] and I find myself not only interested but also inspired by its contents. All over this country in small cities and towns there are families such as those Miss Page describes. They tend to group together in neighborhoods of rundown houses and shacks in the least desirable part of town. The rest of the community expects problems from these people, tends to overlook infractions of community standards until they become too disturbing, and does not anticipate improvement in their way of life. Perhaps most serious, the children of these families are not expected to rise above this level of living, and they often are treated accordingly. To see social workers recognizing this situation and wholeheartedly trying to do something about it in any locality is encouraging.

The second significant fact to which I would like to call attention is that it is the public welfare agency that is responsible for this effort. For most rural areas the chances for the development of the urban variety of professional social services supported by private funds are negligible. The best hope for obtaining the kind of social service needed is through placing community support behind the strengthening and broadening of the public welfare program. This Vermont effort, jointly supported by public welfare and a foundation, illustrates what can be accomplished through this approach.

The third fact that impressed me was the willingness of the welfare department and of the workers themselves to do what had to be done to help these families and their little community toward better living. Obviously, it would have been desirable to have drawn upon volunteers or other professional services for some of the leadership needed. When such assistance did not materialize, however, rather than let the activities fail and the people of the neighborhood suffer another defeat, these workers filled various leadership gaps themselves. Starting out with an effort to provide casework, they soon found themselves deeply involved in community organization and finally in group work activities. Throughout, however, the goal of helping individual families and the casework effort was maintained.

Rural areas need more workers with the zeal of these people, more public welfare agencies with the flexibility to experiment, and more foundations willing to support such efforts.

Maurice O. Hunt
Director, National Survey Service, New York

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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PARENT EDUCATION AND THE BEHAVIORAL SCIENCES: relationships between research findings and policies and practices in parent education. Armin Grams. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 379. 1960. 52 pp. 25 cents.

This publication is a summary of the 1958 parent education conference jointly sponsored by the Children's Bureau and the Institute of Child Development and Welfare, University of Minnesota. It summarizes the major issues discussed by research specialists which resulted in a listing of the research problems that emerged during the conference in the field of parent-child relations, child development, and family interaction.

CLINICAL PROGRAMS FOR MENTALLY RETARDED CHILDREN; a listing. Rudolf Hormuth. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1960. 28 pp. Single copies free on request.

This third and revised listing of special clinical facilities throughout the United States for mentally retarded children, provides information about the types of facilities reported, where they are, and who directs them. No evaluation is made of the quality of services rendered. The information reported in the listing was provided by the clinics.

SUPPORT FROM ABSENT FATHERS OF CHILDREN RECEIVING ADC, 1955. Saul Kaplan. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance. PA Report No. 41. 1960. 112 pp. 65 cents.

Final report of a survey of ADC families with absent fathers, conducted by the Bureau of Public Assistance in 1955. (See CHILDREN, March-April 1958, p. 74.) Major highlights of these findings appeared in the *Social Security Bulletin* of February 1958. The current report includes details about the States and analytical findings not previously published.

JUVENILE-COURT STATISTICS—1959. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 61. 1960. 18 pp. Single copies free.

The year 1959 showed the lowest annual increase in reported court cases of juvenile delinquency in the past decade according to this bulletin. Contrary to the trend in other years, this increase of 2 percent was lower than the increase in child population. Delinquency cases handled in urban courts fell 2 percent; while those in semiurban and rural courts increased by 7 and 15 percent, respectively, following the pattern for all three types in previous years. However, the semiurban and rural courts, the report points out, handle only about two-fifths of all the court juvenile delinquency cases in the Nation.

CHILD WELFARE STATISTICS 1959. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 60. 1960. 32 pp. Single copies available from the Bureau without charge.

Presents statistics in tabular form on children receiving child welfare services from State and local public welfare agencies; personnel in these agencies; selected expenditures for public child welfare services; and adoptions. Highlights of the data are interpreted in a section preceding the publication's 27 tables.

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